Authorization for Disclosure of Health Information

[COMPLETE ALL SECTIONS OF THIS FORM -- PLEASE PRINT]

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the identified entity to release your protected health information to a person or organization that you choose.

Section A. Patient Information: *(individual whose information will be released)*

Name: (First, Middle, Last, Title)		**Date of Birth:** (Month/Day/Year)
Address:	**City/State/Zip Code:**	**Telephone Number:** ( ) --

Section B. Identified Entity *(organization that will release your information)*

I authorize Fort Washington Radiological Associates to release my protected health information as described below.	1244 Fort Washingotn Avenue Fort Washington, PA 19034

Section C. Recipient: *(person or organization that will receive your information)*

Person's Name or Organization:		**Telephone Number:** ( ) –
Address:	**City/State/Zip Code:**	**Fax Number:** (if available) ( ) –

Section D. Description of Information to be Released: *(what type of information will be released)*

Check ONLY ONE box:

☐ **All information related to the provision of, and payment for, my health care benefits or services**

☐ **Specific information as described below:**

____

SPECIAL AUTHORIZATION (if applicable)

State law requires that you give specific permission to release information related to the testing, diagnosis, and/or treatment for any of the conditions listed below. Please indicate your authorization for the above entity to release any of the following information by **signing your initials in the box next to all applicable types of information**:

[ ] HIV/AIDS [ ] Mental/Behavioral Health [ ] Substance/Alcohol Abuse

NOTE: A witness signature must be obtained to authorize the release of information related to any initialed conditions

Section E. Purpose of Release: *(reason for releasing the information)*

☐ Patient's request ☐ Continuation of medical treatment ☐ Payment of bill ☐ Worker's Compensation ☐ Educat ion

☐ Legal purposes ☐ Insurance purposes ☐ Other (specify): ______________________

NOTE: If you do not indicate a Purpose of Release, a default purpose of release on "patient's request" will be used.

Section F. Expiration: *(when this authorization will end)*

This authorization will expire upon the following date, event, or condition*:

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NOTE: If an expiration date or event is not specified, a default date of two years from the date of this authorization will be used.

*You may revoke this authorization at any time by submitting a request in writing to the entity identified in Section B. Revoking this authorization will not apply to any information that has already been released in response to this authorization.

Section G. Approval: *(you OR your personal representative must sign and date this form in order for it to be complete)*

I understand that this authorization to release information is voluntary and that my refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Montgomery County Advanced Medical Imaging to release information as described above.

Patient Signature:	**Personal Representative Information:** A Personal Representative is a parent/guardian or other person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file with the entity identified in Section B, or submitted with this form.
________________ (Print Name) ________________ (Signature of Patient) ________________ (Date)	________________ (Printed Name of Personal Representative) ________________ (Description of Representative's Authority) ________ (Date) ________________ (Signature of Personal Representative) (____)____-______ (Telephone Number)