



Homeless Advocacy Project

A legal aid project of the Philadelphia Bar Association

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Philadelphia, PA 19102

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www.homelessadvocacyproject.org

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Name of Patient _____ SSN _____

Date of Birth _____ Phone Number _____

I hereby authorize _____ to release to

(Name of person, law firm, agency or institution or other)

(Street) (City) (State) (Zip Code)

Reason for Request _____
(My personal records, legal, sharing with health provider, other)

Date/Dates of Information to be Disclosed _____

Type of Information to be Disclosed _____

I understand that the information in my health records may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This consent is subject to revocation (in writing) to the above named facility at any time except to the extent that the person who makes the disclosure has already taken action in reliance on it. If not previously revoked and unless I specify differently, this consent will terminate ONE YEAR from the date of signature.

Signature of Patient or Legal Representative Date

{If signed by legal representative, relationship to patient _____}

Signature of Witness Date

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
Note to recipient of protected information: This information has been disclosed from records protected under Pennsylvania law which prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the individual to whom it pertains.