ELIZABETHTOWN FAMILY HEALTH CENTER

300 Maytown Road, Elizabethtown, Pa 17022
Phone: (717) 367-1430 Fax: (717) 367-2895

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____
Patient Name Birthdate- Month/Day/Year

_____ _____
Address Home Phone #

_____ _____
Work Phone #

_____ _____
City State Zip Social Security #

I hereby authorize **ELIZABETHTOWN FAMILY HEALTH CENTER** to:

_____ Receive From _____Release To (Please allow one to two weeks to copy records)

_____ _____
Name of Doctor, Agency, Institution or Other Phone # of Facility

I give special permission to release any information regarding the following: (**initial** all:Records **will not** be sent without intials)

_____Drug and Alcohol Use _____Psychiatric/Mental Health _____HIV/AIDS

I understand that I may revoke this consent at any time by notifying **ELIZABETHTOWN FAMILY HEALTH CENTER** in writing except to the extent that action has been taken in reliance on it. If not previously revoked, this consent will automatically expire in 90 days from the date signed.

This information is being disclosed to the above person, organization, or agency from records whose confidentiality may be protected by Federal and/or State statutes including Pennsylvania Law, Act 63 and/or Pennsylvania P.L 817 and/or Pennsylvania Law, Act 148. These regulations limit the right to make further disclosure or this information without the prior written consent of the person to whom it pertains.

Reason for request: _____Insurance Change _____Moving
_____Second Opinion only; please keep records active
_____Dissatisfied with **ELIZABETHTOWN FAMILY HEALTH** due to the following reason(s):

_____

_____

_____Other:_____

Please note: There will be a $ fee plus postage for medical records when requested for personal use or for transfer of care to another physician. HEALTHPORT corporation has been contracted to provide this service and will invoice you directly. Questions may be directed to HEALTHPORTS Customer Service Dept. at 1-800-822-1665.

_____ _____
Date Signature of Patient/Responsible Party