Consent for Release of Information

Patient Name ___________________________ S.S.# ________________________ Date of Birth ________________

Patient Address ____ Telephone Number ________________

I, _____________________, do hereby consent to and authorize HealthWorks to:

***Disclose to**:* Name of Doctor/Hospital/Insurance Company/Other Agency: ___________________________________

Attention: __________________________ Address: ____
for the purpose of: ____

Information from within HealthWorks records relating to my identity, diagnosis, prognosis, or treatment. However, I do not give permission for any other use or re-disclosure of this information.

___ ***Do not Disclose.*** I will return to HealthWorks and personally receive the information.

Special authorization for release of mental health/alcohol or drug patient records. (If under 14 years of age, parent or guardian must sign).
Check box if this information is to be released:
❑Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above.

ALL information released will be handled confidentially in compliance with the Federal Privacy Act (PL92.282) and the Pennsylvania Mental Health Procedures Act, to inspect the material released. I have been informed of my right, subject to Section 7100.11.3 of the Pennsylvania Mental Health Procedures Act, to inspect the material released.

Special authorization for release of patient records containing HIV information:
❑ Copies of medical records including information of the diagnosis and/or treatment of AIDS/HIV (including testing) may be released to the recipient as noted above.

The information to be released is:

❑History & Physical	❑Physician Progress Notes	❑Laboratory Results
❑Discharge Summary	❑Physician's Orders	❑Entire Record
❑X-Ray Report	❑Clinic Notes	❑Other ____

❑EXCEPTION: I do not give permission to release (please specify): ____________________________________

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given.

Dated this _____________________________ day of ______________________________ 20 ____

Consent expires the _____________________ day of _______________________________ 20 ____

PATIENT SIGNATURE ___________________________________ WITNESS _________________________________

SIGNATURE OF PARENT/LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE: _____________________________

❑ Unable to sign because: _____________________________________ Witness______________________________

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