PENNSYLVANIA AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I,_____,HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS LISTED BELOW:

Patient Name:_____**Date of Birth:**_____

Address (street, city, state, zip):_____

Telephone: _____

Provider or facility authorized to release information: _____

Address (street, city, state, zip)_____

Person or entity authorized to receive information: Merion Family Dermatology, Dr. Radkevich-Brown

Address (street, city, state, zip)225 E City Ave, Ste 205, Bala Cynwyd, PA 19004 fax 610-273-5897

Dates of Service: ■ All ☐ Specific Dates of Services:_____

Description of Information: ☐ Entire Record ■ **O**thers:last 2 clinic visit notes and all pathology reports

Special Records: Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. (See waiver below).

☐ Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)

☐ Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)

☐ Include AIDS/HIV – Related Records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)

☐ All AIDS/HIV-Related Record ☐ Limited AIDS/HIV-Related as follows: _____

☐ Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively)

Purpose of Release of Information: ☐ Transferring Medical Care ☐ Moving ■ Other at patient's request

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1. This authorization will expire: ☐ Date:_____ ☐ Event:_____ ☐ One year unless otherwise specified, this authorization will expire 1 year after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation.
3. This authorization is voluntary.
4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations. .
5. I understand that this information may be re-released by the recipient and no longer protected.
6. By signing below, I certify that I understand the nature of this Release.
7. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
8. If mental health records are being released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33, to inspect the material to be released.
9. If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
10. **By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.**

    This waiver is applicable only to this request and is not meant to be a general waiver.

_____ _____

Signature of Patient or Patient's Representative/Guardian **Date**

_____ _____

Printed Name of Patient's Representative/Guardian **Relationship to the Patient**

Date Copied & Notified:_____