AUTHORIZATION TO ACCESS/RELEASE HEALTH INFORMATION

CITY OF PHILADELPHIA
DEPARTMENT OF PUBLIC HEALTH
AMBULATORY HEALTH SERVICES

IDENTIFYING INFORMATION

Name Printed: ______________________________

Date of Birth: ______________ Date of Visit/Treatment: ______________________

Patient's Address: ______________________________

I hereby authorize Health Center:

To release to **RECORDS DEPOSITION SERVICE, INC.** **P 248.357.3330**
PO BOX 5054 **F 248.357.3337**
SOUTHFIELD, MI 48086-5054

☐ medical progress notes ☐ lab results ☐ consultation reports ☐ x-ray examinations and reports ☐ other ____________

☐ for restoration of public utilities

as well as any other treatment information provided to me personally or to my

child ______________________________ for the purpose of
(Name)

DISCOVERY BEFORE TRIAL

(at my individual request, legal, sharing with healthcare provider, other)

This authorization is **valid for 1 year beginning on** ______________________ .

- I understand that: I may revoke this authorization at any time by dated written communication to this **health center** (a revocation does not apply if the healthcare center already took action upon the initial request) and that in any event this authorization shall immediately **expire one year** from the date of my signature; and
- Once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations; and
- I do not have to sign this form to get treatment or other benefits unless the reason for the disclosure is solely for the use of a third party.

Note to recipient of protected information: 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 written consent of the individual to whom it pertains.

______________________________ ______________________
(Signature of Patient /Parent/Legal guardian) *(Date Signed)*

If signed by legal guardian, relationship to patient ______________________________

______________________________ ______________________
(Signature of Witness) *(Date Signed)*

SPECIAL AUTHORIZATION FOR RELEASE OF MENTAL HEALTH/ALCOHOL DRUG ABUSE AND HIV TESTING/TREATMENT RECORDS.

☐ My diagnosis and/or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the authorization above.

☐ My diagnosis concerning mental health may be released to the recipient noted on the authorization above.

☐ My diagnosis and/or treatment concerning my HIV testing/treatment may be released to the recipient noted on the authorization above *(if under 14 years of age parent/guardian must sign). If not checked and signed it may be impossible to release your health record.*

SIGNED ______________________________ ______________________
(Patient/Parent/Legal guardian Signature) *(Date Signed)*