111 Arrandale Blvd.
Exton, PA 19341
(610) 363-2532 phone
(610) 363-0210 fax

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

A copying and mailing charge (and chart review charge, if required) will be based on our costs. The practice must receive payment from the patient or remuneration from a third party in exchange for using, mailing or disclosing the PHI. I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) by written communication to the "Privacy Officer," ENTACC, 111 Arrandale Blvd, Exton, PA 19341 under Pennsylvania Law (Act 148). If psychological reports are to be sent, I have been informed of my right, subject to Section 5100-34 of the Mental Health Procedures Act, 1984, to inspect the information to be released, I do not have to sign this authorization in order to receive treatment from ENTACC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I understand that I may inspect and/or copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the Privacy Officer as listed above.