1740 South Street, Suite 300, Philadelphia, PA 19146
TEL: 215-732-0876
FAX: 215-732-1812
WEBSITE: www.phaadultmedicine.com
Download: Healow App for Patient Portal

FORM 4 : AUTHORIZATION TO RELEASE MEDICAL RECORDS to
PHA-ADULT MEDICINE, 1740 South Street, Suite 300, Philadelphia, PA 19146
For Continuity of Care **HIPAA Compliant FAX: 844-637-0750**

Name (print) ____ DOB ____________ Last 4 SSN ______

INFORMATION TO BE RELEASED FROM:

Name of facility or provider:
____

Address
____

INFORMATION TO BE RELEASED: (Check one)

___The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
___All Medical records
___Specific information (Please specify): ____

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. See exclusion below.

EXCLUDE the following information from the records released (please initial.)

___Sexually transmitted infections ___Drug/Alcohol abuse/treatment & diagnosis
___HIV/AIDS diagnosis/treatment/testing ___Mental illness or psychiatric diagnosis/treatment

My RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). This authorization is good for ninety (90) days from date of signature. I may revoke this authorization in writing.

Signature: ________________________________ Date: ______________
(Patient, guardian* or Authorized Representative*) *proof may be required.

Verbal Release of Patient Health Information

If the patient is deemed competent but not physically able to provide signature, a verbal consent will be accepted from the patient provided it is witnessed by two people.

"We, the undersigned, certify that ____was physically unable to provide a signature that he/she understood the nature of this release and freely gave his/her consent."

X____ ______________________ ___________
Signature of Witness #1 Title Date
X____ ______________________ ___________
Signature of Witness #2 Title Date