



**HEALTH CARE FOR THE HOMELESS (PEDS)
AUTHORIZATION TO RELEASE/REQUEST PROTECTED HEALTH INFORMATION**

Name SSN# Date of Birth

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I, Authorize: _____ To Release to: _____

This information is to be limited to the following: Date(s) of service: _____

- History and Physical
- Medical Progress Note
- Nursing Notes
- Medication Sheet
- Other (please specify) _____
- The information designated above is intended to include information received from a third party provided the third party has not prohibited re-disclosure.
- Labs/X-Rays/Consultations
- Mental Health Records including psychotherapy notes
- Addictions Records
- Social Service Records

- Purpose of Request:**
- At the request of the individual
 - Legal
 - Sharing with other Health Care Providers as needed
 - Other (please specify below)

Release of Special Information: (circle appropriate response and initial if applicable)

I DO / DO NOT authorize to release information pertaining to psychiatric, drug/
or alcohol abuse, sexually transmitted diseases. Initials: _____

I DO / DO NOT authorize to release information pertaining to HIV/AIDS related
testing, diagnosis and/or treatment. Initials: _____

Individual rights: I understand the following:

- This request will be processed within 30 days.
- I need not sign this form to ensure healthcare treatment or payment.
- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of the Medical Record Department at HCH.
- My right to revoke does not apply to information that has already been released on the basis of this authorization.

- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal rule on privacy.
- This authorization will expire in 180 days unless revoked or another date otherwise specified.

(Parent/Guardian Signature)

(Witness Signature)

Date

08/2013