BERKS COUNTY

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Client Name: _____ Date of Birth: _____

Client ID #: _____

Today's Date: _____

I, _____ [print name], hereby authorize the HIPAA Privacy Officer of **Berks County** to release information from my records as specified below, to:

Name of Person:

_____ Title: _____

Name of Entity:

_____

Address: _____

I authorize the following information to be released:

- ☐ Complete Medical Record
- ☐ Special Consultation
- ☐ Progress Notes (excludes Psychotherapy Notes)
- ☐ Treatment Summary
- ☐ Social History
- ☐ Substance Abuse*
- ☐ Alcohol*
- ☐ HIV/AIDS Status*
- ☐ History
- ☐ Physical

Other (please specify) _____

Authorized Information will be used and/or disclosed for the following purposes:

- ☐ At the request of the individual (check box if applicable)
- ☐ Other (list each purpose of the use(s) or disclosure(s) in the space provided.):

_____

_____

- I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations (also known as the HIPAA Privacy Rule), the Authorized Information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I understand that I have the right to revoke/withdraw this authorization, in writing, at any time by notifying the HIPAA Privacy Officer of Berks County, and that the revocation/withdrawal will be effective except to the extent that Berks County has already taken action in reliance on my authorization.

My written statement that I want to revoke/withdraw my authorization should be delivered to:

HIPAA Privacy Officer
Berks County
Beth K. Schiepan, Director of Human Resources
633 Court Street- 8th floor- Human Resources
Reading, PA 19601

- I understand that Berks County will not condition my treatment or access to services upon whether or not I sign this Authorization. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my access to treatment or services by or through Berks County.

*Note to Recipient:
This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CRF-Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose. This release shall be valid for a period no longer than 3 months unless otherwise specified.

This authorization will expire at the earlier of _____ [Date] or the date the following event occurs: _____
(Describe event or otherwise write not applicable)

Signature of Client:
_____ (Signature) _____ (Date)
_____ (Print Name)

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here (attach any additional verifying information):

_____

_____ (Signature) _____ (Date)
Personal Representative
_____ (Print Name)

For Office Use Only:
Staff person receiving Authorization:_____
(Signature)
_____
(Print Name)

Date Authorization received: _____