

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: _____