



FORM 7

PHILADELPHIA HEALTH ASSOCIATES
ADULT MEDICINE, P.C.

www.phaadultmedicine.com

1740 South Street, Suite 300
Philadelphia, PA 19146
Fax: 215-732-1812
TEL: 215-732-0876

Shahana N. Karim, MD
Jon A. Shapiro, MD
Wilbert R. Warren, MD, FACP

CONSENT FOR RELEASE OF MEDICAL RECORDS with SENSITIVE INFORMATION

This form must be presented in person by the patient or guardian on file.

Name: _____ DOB: _____ Med Rec# _____
I, _____ authorize _____ to
disclose to/obtain from _____
(Circle one) (Person/Organization to whom/which information is disclosed)

(Street Address, City, State, Zip Code)

List Specific Information to be released:

NOTICE TO PATIENT

If the information/medical records requested contain psychiatric, drug abuse, or alcohol abuse treatment records/information, this information is protected by Federal Confidentiality Rules (42 C.F.R., Part 2). The Federal and/or state law rules prohibit this facility from making any further disclosure of these information/records unless further disclosure is expressly permitted by the patient's written consent. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse. If the information/medical records requested contain HIV (Human Immunodeficiency Virus) or HIV-related information, this information is protected by Pennsylvania law. Aside from certain limited disclosures allowed or mandated by law, the patient's written consent is required if the information/medical records requested contain alcohol abuse, drug abuse, psychiatric treatment, HIV or HIV-related information.

By signing this consent to release confidential information/medical records,

I am or I am not expressly consenting to release information/medical records that may contain information concerning alcohol abuse, drug abuse, psychiatric treatment, HIV or HIV-related information. In authorizing the release of the information/medical records containing alcohol abuse, drug abuse, psychiatric treatment, HIV or HIV-related information, the purpose for the release of the information/medical records is: _____

I understand that I may cancel this authorization at any time, except that this information/medical records has already been released under this authorization. Unless otherwise specified, this authorization is valid today, and remains valid for six (6) months from today. The facility, its employees and offices are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient's Signature

Date

Guardian's Signature

(Relationship to Patient)

Date