



FORM 8

**PHILADELPHIA HEALTH ASSOCIATES
ADULT MEDICINE, P.C.**

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**Patient Authorization for Practice to Release
Protected Health Information to Third Parties**

By signing this authorization, I authorize Philadelphia Health Associates - Adult Medicine, P.C. to use and/or disclose certain protected health information (PHI) about me or for the party or parties listed below.

This authorization permits Philadelphia Health Associates - Adult Medicine, P.C. to use or disclose to

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):

Reason for Disclosure:

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Philadelphia Health Associates - Adult Medicine has acted in reliance upon this authorization. My written revocation must be submitted to the practice's Privacy officer.

Signed by: _____
Patient Name Signature

Guardian or Representative Signature Relationship to patient

Date