HAP
LEGAL SERVICES TO END HOMELESSNESS

HOMELESS ADVOCACY PROJECT
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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Name of Patient _____ SSN _____

Date of Birth_____ Phone Number _____

I hereby authorize_____ to release to

_____
(Name of person, law firm, agency or institution or other)

_____
(Street) (City) (State) (Zip Code)

Reason for Request _____
(My personal records, legal, sharing with health provider, other)

Date/Dates of Information to be Disclosed_____

Type of Information to be Disclosed_____

_____

I understand that the information in my health records may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This consent is subject to revocation (in writing) to the above named facility at any time except to the extent that the person who makes the disclosure has already taken action in reliance on it. If not previously revoked and unless I specify differently, this consent will terminate ONE YEAR from the date of signature.

_____ _____
Signature of Patient or Legal Representative Date

{If signed by legal representative, relationship to patient _____}

_____ _____
Signature of Witness Date

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Note to recipient of protected information: This information has been disclosed from records protected under Pennsylvania law which prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the individual to whom it pertains.

This authorization is subject to revocation at any time except to the extent that information has been disclosed in reasonable reliance on it.
This authorization shall be in full force and effect for a period of one year from the date it was signed by me.

Executed this _____ day of _____, 20_____.

_____ _____

Name (Please Print) Advocate (Please Print)

_____ _____

Signature Signature