RECORD RELEASE/AUTHORIZATION
to USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: ____

Date of Birth: ____________________________________ Social Security: ______________________________

I hereby authorize the following office or organization to copy and forward my medical records.

Practice Name: ____

Address:_____________________________________

City: _________________________ ________________ State: _________ Zip Code: ____________________

Phone: _______________________________________ Fax: _______________________________________

Please send my records to: Setzer Personal Physicians
645 North 12th Street, Suite 300
Lemoyne, PA 17043
Phone: (717) 724-0290 Fax: (717) 695-6290

Information to be sent:
_____All records
_____ Records pertaining to
_____All records from ___________to __________
_____Records not to be released ____

I authorize the release of the following records under the same terms and conditions. (Initial each of the following 4 items)

Mental Health/Psychiatric ___yes___no (includes headaches, stress, anxiety, depression, psychotherapy, etc.)
Substance Abuse ___yes___no (includes tobacco use, alcohol, controlled substance, etc.)
HIV/AIDS ___yes___no (includes advice, reports, statistical data, etc.)
Sexual Abuse/Sexual Assault ___yes___no (includes advice, reports, statistical data, etc.)

I hereby release Setzer Personal Physicians from all liability and all claims of any nature whatsoever pertaining to the disclosure of information contained in my medical records. I authorize any physician nurse or other health care professional who has attended to me or any hospital at which I have been confined to furnish to the above recipient any all information which may be requested regarding my physical or mental condition treatment.

____ ______________________________
Signature of Patient or Patinet's Representative/Guardian Date

____ ______________________________
Printed Name of Patient's Representative Relationship to Patient

____ ______________________________
Signature of Witness Date

A photocopy of this request is to be considered as valid as the original.
This release will remain valid for 90 days from the date of signature unless I earlier revoke my consent.

Right to Revoke. You may revoke this authorization at any time except to the extent that we have relied on the authorization. TO revoke this authorization you must submit a written revocation to our office.

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party, e.g. a pre-employment physical.

HIV/AIDS related information is included in these records, it has been discussed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless future disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV related information.