PROJECT HOME
HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION

Authorization for Disclosure of Health Information

INFORMATION ABOUT THE PATIENT OR CLIENT		
*Patient/Client Name	*Date of Birth	Record Number
*Address	Telephone	*Last four digits of SSN

PURPOSE OF THIS FORM (*please check one or both)

- ☐ I would like Project HOME to **release** some of my health information to the following person or institution:
- ☐ I would like Project HOME to **receive** some of my health information from the person or institution:

*Name of Person or Institution:

*Address

*City/State/Zip Code	Telephone	Fax

INFORMATION TO BE DISCLOSED (*please check all that apply)

- ☐ Case management progress notes and service plans
- ☐ Medical history and physical examination
- ☐ Medical progress notes and treatment plans
- ☐ In-patient hospital records
- ☐ Emergency department records
- ☐ Radiology reports (x-rays, cat scans, MRIs, etc).
- ☐ Lab reports
- ☐ Psychotherapy Notes and treatment plans
- ☐ Billing records
- ☐ Other (please specify): _____

Covering the period(s) of: _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I further understand that information in response to this request may be related to diagnosis or treatment for HIV/AIDS, psychiatric care and treatment, and treatment for drug and alcohol abuse, which may **NOT** be re-disclosed by the recipient without my express written consent. **Please check the appropriate box(es) below:**

*AIDS/HIV Information	*Psychiatric Care/Treatment	*Treatment for Drug & Alcohol Abuse/Dependence
☐ Yes, if applicable, okay to disclose	☐ Yes, if applicable, okay to disclose	☐ Yes, if applicable, okay to disclose
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

Please mail/fax requested information to:	**Fax: 215-236-2308**
Project HOME Healthcare Services	**Phone: 215-320-6187**
2144 Cecil B. Moore Ave, Philadelphia, PA 19121	

AUTHORIZATION (*please check one)

Length of authorization:

- ☐ 1 year from date of authorization
- ☐ Other date – please specify (not to exceed one (1) year from date of authorization): _____

By signing below, I authorize Project HOME and/or Person or Institution named above to release my health information as detailed herein:

_____

*Signature of Patient/Client or Personal Representative Print Name Date

*If this Authorization is signed by someone other than the patient or client, please state reason (i.e. person is a minor):

_____

REVOCATION INFORMATION

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing to the address below. I understand that the revocation may not apply to information that has already been released in response to this authorization.

Send your revocation to: Project HOME, Privacy Officer, 1515 Fairmount Avenue, Philadelphia, PA 19130.