Commonwealth of Pennsylvania, Department of Human Services
Authorization for Use or Disclosure of Personal Information

1. I authorize the Department of Human Services, Torrance State Hospital, PO Box 111, Torrance PA 15779 to use/disclose individual information as described below from the records of:

Name: _____ Date of Birth: _____
Address: _____ Telephone: _____
ID number (Medical Record Number or Social Security Number) _____

2. Reason for disclosure: _____
(Describe each specific purpose – if disclosure is at individual's request and information to be disclosed does not include drug and alcohol treatment information, may state, "At the request of the individual")

3. I understand that:

a. this authorization may be revoked at any time by writing to the covered entity identified in section 1 except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.

b. the Department and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.

c. information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified in section A.2 below and is no longer protected by federal privacy regulations.

d. the Department, its programs, services, employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

e. I may refuse to sign this authorization.

PART A-General Information

A.1 Information to be disclosed (Identify specifically the information to be used/disclosed. If information to be used or disclosed includes mental health, drug and alcohol, or HIV-related information, please complete section on back of this form that relates to that information):

☐ **Face Sheet**	☐ **CITP - Plan of Care**	☐ **Treatment Review - ___ months**	☐ **Psychiatric Assessment**
☐ **Medical Assessment**	☐ **Nursing Assessment**	☐ **Social Service Assessment**	☐ **Psychological Evaluation**
☐ **Dental Assessment**	☐ **Medication List**	☐ **Allergy & Immunization & PPD**	☐ **Progress Notes- _____Days**
☐ **Labs**	☐ **RPR**	☐ **Hepatitis Profile**	☐ **X-Rays**
☐ **Diagnostic Testing (EKG - EEG - Bone Density - Sonogram - CAT scan - Mammogram)**			☐ **Consults**
☐ **Physical Therapy**	☐ **Speech Therapy**	☐ **Ongoing Verbal Communication**	☐ **MAR**
☐ **Discharge summary**	☐ **Discharge Instructions**		
☐ **Other** _____			

A.2 This information is to be disclosed to _____

_____
(Insert name, title, address and telephone number of the individual/organization to whom disclosure is to be made)

A.3 This authorization expires as indicated. If no date or event specified this authorization will expire in 180 days.

_____ Once acted upon

_____ Other (specify date or event) _____

PART B-Special Categories of Medical Information

B.1 Drug and Alcohol Information

If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Part A of this form.

☐ Yes ☐ No or Not Applicable

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

B.2 Mental Health Information

If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form.

☐ Yes ☐ No or Not Applicable

B.3 HIV/AIDS Information

If my medical record includes HIV/Aids information, I want to send that information to the individual/organization identified in Part A of this form.

☐ Yes ☐ No or Not Applicable

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further 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 Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

* *

_____ _____ _____

Signature of Individual or Personal Representative | Date | (If Personal Representative - State Relationship to Individual)

_____ _____

Signature of Witness | Date

VERBAL CONSENT ONLY: **The foregoing person, who *is unable to provide a signature or not physically present*, freely gave a VERBAL CONSENT to the release of information requested. He/She had the request read to him/her and understands the nature of the release. He/She also understands that this consent may be orally revoked at any time.**

NAME: _____ **Relationship if other than patient** _____

WITNESS: _____ **WITNESS:** _____ **DATE SIGNED:** _____

REASON FOR VERBAL CONSENT: _____

FOR MEDICAL RECORD DEPARTMENT USE ONLY

Date Released: _____ **Released By (Initials):** _____