Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

Social Security Number or MA ID: _____

II. AUTHORIZATION. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("Authorized Party") to use or disclose the following:

Any medical-related information needed to verify my receipt of medical services for the purpose described below

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

Name: Phyllis Hatch

Address: 980 Harvest Dr., Blue Bell, PA 19422

Phone: (215) 542 - 7433 Fax: (215) 542 - 0699

E-Mail: phatch@suburbantransit.org

IV. PURPOSE. The reason for this authorization is:

To verify attendance to the appointment for medical services for which you received transportation through the Medical Assistance Transportation Program.

V. TERMINATION. This authorization will terminate:

Upon sending a written revocation to the authorized party.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____

☐ - **Other:** _____

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____