Authorization to Use and Disclose Health Information

pa health & wellness

Notice to Participant:

- Completing this form will allow PA Health & Wellness to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to sign this form or give permission to use or share your health information. Your services and benefits with PA Health & Wellness will not change if you do not sign this form.
- Right to cancel (revoke): This authorization/consent form is subject to revocation at any time except to the extent that PA Health & Wellness or other lawful holder of your health information that is permitted to share it has already acted in reliance on it. If you want to cancel this Authorization Form, fill out the Revocation Form on the last page and mail it to the address at the bottom of the page.
- PA Health & Wellness cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- Fill in all the information on this form. When finished, mail it to the address at the bottom of the first page.

PARTICIPANT INFORMATION:

Participant Name (print): _____

Participant Date of Birth: _____ Participant ID Number: _____

I give PA Health & Wellness permission to use my health information for the purpose identified or to share my health information with the person or group named below. The purpose of the authorization is:

☐ to allow PA Health & Wellness to help me with my benefits and services, or

☐ to permit PA Health & Wellness to use or share my health information for _____ .

PERSON OR GROUP TO RECEIVE INFORMATION (add additional Persons or Groups on page 2):

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____ - _____

I AUTHORIZE PA HEALTH & WELLNESS TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION:

☐ **All of my health information INCLUDING:** genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed: _____); **OR**

☐ **All of my health information EXCEPT (check all boxes that apply):**

- ☐ Genetic information, services or tests
- ☐ AIDS or HIV data and records
- ☐ Drug and alcohol data and records
- ☐ Mental health data and records (but not psychotherapy notes)
- ☐ Prescription drug/medication data and records
- ☐ Other: _____

Authorization End Date: _____ /_____ /_____ *(date the authorization ends unless cancelled)*

Participant Signature: _____ **Date:** _____ /_____ /_____

(Participant or Legal Representative Sign Here)

If you are signing for the Participant, describe your relationship below. If you are the Participant's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).