CityLife Health

HIPAA Authorization for Release of Protected Health Information

Patient's Name: _____ **Patient's Date of Birth:** _____

Personal Representative's Name and Address (if applicable): _____ *Relationship to Patient (if applicable)*: _____

The information I am authorizing to be shared:
I authorize the release of my information pertaining to physicals/wellness exams, vaccinations, and/or relevant ongoing treatment information or medical history.

Any additional information: _____

***The persons or organizations I am authorizing to share my information*:**
CityLife Health ("CityLife") is authorized to release/request the information indicated above to/from the following person or entity:

Name: **The School District of Philadelphia**
Address: **Education Center, 440 North Broad Street, Philadelphia, PA 19130-4015**
School Health Nurse Supervisor or her Designee
Email: healthrecords@philasd.org

The reason I am requesting that my information be shared:
The disclosure/request is made for collaboration between CityLife and the school or school system and for continuity of care purposes.

My authorization and my rights:
I hereby authorize the use or disclosure of the protected health information indicated above, and by signing below, I understand that:

1. I may refuse to sign this authorization.
2. My l protected health information will be released to the person or entity I have listed above.
3. My protected health information may include sensitive health information, including details about my mental health; drug and alcohol use; testing for or diagnosis of HIV/AIDS or other communicable diseases; and/or genetic testing.
4. I have the right to revoke this authorization in writing at any time. However, any action taken based on this authorization cannot be reversed, and my revocation will not affect any action that has already been taken.
5. Unless this authorization is revoked, it will expire when the patient is no longer enrolled in the school and/or school system.
6. The protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient of the information, and the information may no longer be protected by state or federal privacy laws or regulations.
7. CityLife may not condition my treatment or payment on whether I sign this authorization.
8. I may receive a copy of this authorization upon request.

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative (if applicable) Date

_____ _____
Witness Signature Date