

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize _____ (“Covered Entity”) to release my health information described below to:

Recipient Name: Berks County Medical Society, Patient Relations

Recipient Address: 1170 Berkshire Blvd., Wyomissing, PA 19610

Recipient Telephone Number: 610-375-6555

Documents/Information to be Released:

All relevant information associated with my treatment.

Purpose of Disclosure:

At the request of the individual.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1966, and its implementing regulations (“HIPPA”). I understand that I have the right to revoke this authorization at any time prior to covered entity’s compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in Covered Entity’s Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to:

Attn: Privacy Officer

I understand that I am not required to sign this authorization and that Covered Entity may not condition treatment on my execution of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPPA.

This authorization expires upon Covered Entity’s release of the information described above or thirty days after the Date of authorization, as set forth below, whichever comes first.

I hereby acknowledge receipt of a copy of this authorization.

Signature of Individual or Personal Representative

Description of Person Representative’s Authority

Date of Authorization

