Intercommunity Action, Inc.
PCP Auth to Release Info - From Interact

Client: Test, Test **DOB:** 10/06/1987 **Gender:**Female **ID#** 00000001 **Intake:** 05/04/2015 05:00am

Client:

Event:

Actual Date:

Staff:

Attached Document: No document attached

No PCP or Client Refused to Sign:

PCP - New:

Organization	Practitioner	Type

Release Information:

I hereby authorize confidential information to be released from my/the client's clinical records pertaining to my/the client's evaluation and treatment:

☐

PCP on file:

Type	Practitioner	Organization Name	Phone	Fax Number	Address
Not on File...					

TO:

Person:

Organization

Address:

Phone#:

FROM:
Person: Medical Records
Organization: Interact
Address: 6122 Ridge Avenue, Philadelphia, PA 19128
Phone#: 215-487-1330 or FAX 215-487-1641

☐

These records are required for the specific purpose of coordinating:

☐ Coordination of Care ☐ Referral ☐ Evaluation ☐ Treatment ☐ Services ☐ Other

--If Other, please specify

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Information to be released from my records covers the time period starting at this date:

To this date:

Information to be released from my records is limited to: (check all that apply)

☐ Current Status ☐ Diagnosis ☐ Medications ☐ Personal and family history of hypertension, diabetes, dyslipidemia, hypertension or cardiovascular disease ☐ Weight and height ☐ Waist circumference ☐ Blood pressure ☐ Progress Summary ☐ Other

If Other was checked, please specify below:

This consent shall be effective from this date:

To this date:

(NOT TO EXCEED ONE YEAR)

I have been informed that I may revoke this authorization at any time by oral or written request to the Behavioral Health Division at Intercommunity Action, Inc. (except to the extent that action has been taken in reliance on this authorization). I have also been informed of my rights to inspect materials to be released (subject to Section 7100.111.3 of the Pennsylvania Mental Health Procedures Act and/or subject to the Pennsylvania Drug and Alcohol Control Act), and that disclosure relating to drug or alcohol abuse or dependency is pursuant to applicable state and federal laws and regulations. Disclosure is also limited to comply with the Confidentiality of HIV-Related Information Act, 1991. Further, I understand that, despite all care taken, information transmitted electronically (faxed) is occasionally received by a party not intended to be the recipient; I release Intercommunity Action, Inc. from all liability should this occur.

☐

I certify that this form has been fully explained to me and that I understand its contents.

☐

Client Signature/Date (or guardian if MH under 14):

To Be Completed and Signed by Two Witnesses if Client is Unable to Sign

Acknowledgement:

Signature of Witness of Person Unable to Sign/Date:

Signature of Witness of Person Unable to Sign/Date:

Client accepts a copy of this Release of Info form:

Client does not want a copy of

this Release form:

THIS AUTHORIZATION IS NOT VALID UNLESS ALL SECTIONS ABOVE ARE COMPLETED

Entered With:

Service Related Encounter Information

Exempt from Billing:

Activity Type:

Client Involved:

Program Providing Service:

Facility Providing Service:

Encounter With:

Service Authorization:

Tasks/Schedules

Next Event Due:

Next Scheduled Event