Family Service ROI PCP

☐ **I do not have a PCP (no signature required)**

Client Name:

Date of Birth:

(D&A, MH, or HIV-related information cannot be used/disclosed in reliance on this form unless specified explicitly as such. D&A and HIV-related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.)

I authorize Family Service to disclose my protected health information to the following person or entity (name/agency/relationship/phone number):

_____

I hereby authorize Family Service Association of Bucks County to use and/or disclose my protected health information only as described below.
This authorization allows Family Service to communicate with and/or disclose records for the following purpose(s):

☐ Continuity and Coordination of Care

☐ Recommendations

This authorization covers the following information about me:

☐ Lab and Medical Test Results

☐ Medication/Prescription Records

☐ Diagnoses and Dates of Services

☐ Evaluations and Assessments

☐ Treatment and Discharge Recommendations

This authorization permits Family Service to release the covered information which it has in its possession. Family Service may release this information to the following person(s) or entity(ies):

This authorization also permits the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to Family Service immediately upon Family Service's request. I understand that I have the right to revoke this authorization at any time either by verbal or written notification to Family Service, which becomes effective immediately. II understand that Family Service may request that I sign a notification form which will be placed in my record. I may not revoke this authorization to the extent that Family Service has already relied upon it or if it was signed as a condition of obtaining insurance coverage.

Family Service is instructed to prohibit re-disclosure by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

I understand that Family Service may not require that I sign this authorization in order to obtain treatment. I have read this authorization or had it explained to me, and I understand its contents.

In absence of revocation, this authorization is signed becomes effective on:_____ and expires on: _____

I am entitled to a copy of this consent form. **Accepted_____** **Refused_____**

_____ _____

Signature of Client Date Signature of Witness Date