HANOVER FAMILY PRACTICE ASSOCIATES
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Read entire document before signing
This authorization gives permission to use or disclose health information about you.

Patient Name: ____

Account Number: ________________________________ **Date of Birth:** _______/________/________

1. **From**: The following individual(s) or organizations(s) are authorized to disclose the health information of the above named individual as described in this authorization:

   Name ____
   Address _______________________________________Phone_____________________Fax____________________

2. **To:** The covered health information may be used by or disclosed to the following individual(s) or organizations(s):

   Name ____
   Address _______________________________________Phone_____________________Fax____________________

3. **Covered health information:** The following health information is covered by this authorization. Please check:

- ☐ Complete medical record
- ☐ Problem List
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history/diagnosis
- ☐ Discharge summary for admission on ____________
- ☐ Lab results (Please list specific tests and dates below.)
- ☐ X-ray and imaging reports (Please list specific studies and dates below.)
- ☐ Consultation report (Please supply consulting physician's name and date below.)
- ☐ Operative report: Procedure _________________ Date _________________
- ☐ Progress note(s): Date ________________ or Range of Dates ______________
- ☐ Treatment Plan
- ☐ Other (please give specific description)

  ____
  ____

Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

4. **Specifically protected information:** The following information is specially protected by state and/or federal law.
Please indicate below whether you would like the following information to be released:

Substance abuse records (drug or alcohol)	Yes _____	No _____	Initials______
Mental health records protected by the Mental Health Procedures Act	Yes _____	No _____	Initials______
HIV/AIDS related information	Yes _____	No _____	Initials______

5. **Other restrictions:** Please specify any other restrictions on the covered information:___________________________
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6. **Purpose:** I am requesting use or disclosure of the covered health information for the following purpose:

- ☐ My personal use
- ☐ Further medical treatment
- ☐ Insurance eligibility or benefits
- ☐ Eligibility for disability benefits
- ☐ Legal investigation or action
- ☐ Other (please describe) ____

7. **I understand that I have the following rights:**

- **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Hanover Family Practice Associates, LLC, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- **Right to revoke.**_ You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:
  Hanover Family Practice Associates, LLC
  Attention: Julie Moul
  100 Penn Street, Suite D
  Hanover, PA 17331
- **Re-disclosure.** I understand that once the covered health information has been disclosed, it may be no longer protected by privacy laws and may be re-disclosed by the recipient.

8. **Expiration.** This authorization expires 1 year from date signed: __________________________________.

I have read and understand this authorization, and authorize the use of disclosure of the covered health information as described in this authorization.

____ ________________________________

Signature of patient (or personal representative) **Date**

Personal Representative Information (as applicable):

____ ________________________________

Name of personal representative **Relationship to patient**

Office fax numbers:	**Dr. Eisenberg**	**717-632-3553**
	Drs. Lunsford and Rein	**717-637-5893**
	Drs. Henke, Dr. Wentz, and Dr. Milcarek	**717-632-1180**
	Physical Therapy Department	**717-633-5675**
	Behavioral Health Department	**717-637-5893**