CATHOLIC CHARITIES FREE HEALTH CARE CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL AND DENTAL INFORMATION

Catholic Charities Free Health Care Center (CCFHCC) is hereby requested to release medical information to the following provider

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I understand that this authorization applies to any and all of my medical/dental information, history, records, diagnoses and reports of lab and radiology tests. These records may include the diagnosis and treatment of alcohol/chemical dependency or HIV, AIDS or any AIDS related condition except as excluded below.

Do **NOT** release information pertaining to:

Alcohol/chemical dependency ______________ HIV _____________

AIDS or AIDS related conditions _____________

Date range of records to be released: from __________________ to __________________.

This consent is valid until the records have been released or for ninety (90) days from the date of signature.

I further understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the CCFHCC's Privacy Contact at 212 Ninth St, Pittsburgh, PA 15222. I understand that this revocation is effective on its receipt at the CCFHCC and that information may have already been released.

Patient name ________________________________ Phone ______________________

Address ______________________________________

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Date of Birth _________________________ SSN _________________________

Signature of Patient or Personal Representative ____

Description of Personal Representative's Authority (if applicable) ______________________________

Witness ____ Date signed____________________