



- ☐ QCHC Family Health Center 2501 W. Lehigh Avenue, Philadelphia, PA 19132 (215)-227-0300
- ☐ Meade Family Health Center 18th & Oxford Streets, Philadelphia, PA 19121 (215)-765-9501
- ☐ Cooke Family Health Center 1300 W. Loudon Street., Philadelphia, PA 19141 (215)-456-6902

Consent to Release Medical Information from
Quality Community Health Care, Inc.

DATE: _____

I: PATIENT IDENTIFICATION SECTION

Patient Name: _____ DOB: _____
Address: _____

II: WRITTEN CONSENT SECTION

I, _____ hereby consent to the release of the following information from
(Patient's Name)
my medical records by ***Quality Community Health Care, Inc., 2501 W. Lehigh Avenue, Phila., PA 19132***
to _____
(Name/Address of Individual/Organization Receiving Information)

Specific Information to be Released:

Specific Purpose of Release:

This written consent is subject to revocation at any time by writing to the physician or practice which is to release the information except to the extent that this physician or practice has already acted in reliance on this consent. With the exception of mental health, HIV related information or drug and/or alcohol abuse records, once your health information is disclosed, it may be re-disclosed by the recipient and may no longer be subject to state or federal law protections. To revoke this consent, simply sign and date the revocation section on your copy of this form and return it to your physician's office. If you do not have a copy, another copy will be provided. If not previously revoked, this consent will remain in force from.

_____ TO _____
(today's date) (specify date consent will expire, not to exceed 120 days)

This consent form has been fully explained to me and I understand its contents. I have been informed of my right under Pennsylvania law to inspect material to be released, subject to the limitations imposed by Pennsylvania regulations, 55 Pa. Stat. section 510033.

Signature of Patient _____ Date _____

Signature of Legal Guardian, Next of Kin, Executor, or Administrator _____ Relationship _____ Date _____

Witness _____ Date _____

Reason consent is signed by person other than patient

III. STAFF IDENTIFICATION SECTION

Name of Person Obtaining Consent _____ Date _____

NOTICES TO ACCOMPANY RELEASE OF INFORMATION

Check Applicable Statement(s)

☐ **STATEMENT TO ACCOMPANY RELEASE OF MENTAL HEALTH RECORDS**

"This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains." 55PaCode section 5100.34(d)

☐ **STATEMENT TO ACCOMPANY DISCLOSURE OF CONFIDENTIAL HIV-RELATED INFORMATION**

"This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose" 35 Pa. Stat. section 7606 (e)

☐ **STATEMENT TO ACCOMPANY RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS**

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Signature of Patient

Date

Signature of Legal Guardian, Next of Kin, Executor, or Administrator

Relationship

Date

Witness

Date

Reason consent is signed by person other than patient

IV. REVOCATION SECTION (to be completed and signed by the patient)

This consent expires on _____

Patient Signature