



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize University of the Sciences in Philadelphia (the “Plan”) to release my health information described below to:

Recipient Name: _____.

Recipient Address: _____

Information to Be Released:

Purpose of Disclosure (explain at the request of the individual):

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations (“HIPAA”). I understand that I have the right to revoke this Authorization, at any time prior to the Plan’s compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in the Plan’s Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

University of the Sciences in Philadelphia
Attention: Eileen M. McGovern, Privacy Officer
600 South 43rd Street
Philadelphia, PA 19104-4495

I understand that I am not required to sign this Authorization and that the Plan may not condition treatment, enrollment in a health benefits plan, or eligibility for benefits on my execution of this Authorization, except that the Plan may require me to sign this Authorization before I am enrolled if it seeks my authorization to make a decision about my eligibility or enrollment or to make an underwriting or risk rating determination. **In no event, however, can such a pre-enrollment Authorization be for the use or disclosure of psychotherapy notes.**

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This Authorization expires upon the Plan's release of the information described above or 90 days after the date of Authorization, as set forth below, whichever comes first.

I hereby acknowledge receipt of a copy of this Authorization.

Print Name

Signature of Individual *or* Personal Representative

Description of Personal Representative's Authority

Date of Authorization