Valley Forge Medical Center and Hospital
Where the healing begins…

1033 WEST GERMANTOWN PIKE
NORRISTOWN, PA 19403
Phone: (610) 539-8500 Fax: (610) 539-0666

Name: _____

Medical Record #: _____

AUTHORIZATION/CONSENT FOR RELEASE and/or RECEIPT OF PROTECTED INFORMATION
Form 6002.1D

I _____, give consent to Valley Forge Medical Center & Hospital to disclose and/or receive information

A.

Choose One: ☐ **TO** ☐ **FROM** ☐ **TO and FROM**

B.

_____
Name of Facility/Person **If Facility: Contact Name Or If Personal: Relationship**

_____ _____ _____
Phone # **Extension** **Fax #**

C. For the purpose of:

☐ Treatment of a medical condition ☐ Substance abuse treatment ☐ Mental health ☐ Aftercare planning
☐ Other: _____

PHI OUT

D. Information to **DISCLOSE TO ABOVE FROM Valley Forge Medical Center** will be limited to:

☐ Presence in treatment ☐ Admission and discharge dates ☐ Aftercare plans ☐ Diagnosis/Prognosis
☐ Progress in treatment ☐ Discharge Summary ☐ Medication Record ☐ Physician's H&P
☐ Psychiatric Evaluation ☐ Lab & Ancillary tests ☐ HIV Related information ☐ Other _____

PHI IN

E. Information to **RECEIVE FROM ABOVE TO Valley Forge Medical Center** will be limited to:

☐ Presence in treatment ☐ Admission and discharge dates ☐ Aftercare plans ☐ Diagnosis/Prognosis
☐ Progress in treatment ☐ Discharge Summary ☐ Medication Record ☐ Physician's H&P
☐ Psychiatric Evaluation ☐ Lab & Ancillary tests ☐ HIV Related information ☐ Other _____

I understand that information disclosed as a result of this authorization/consent may no longer be protected and could potentially by re-disclose. However, such disclosure must by consistent with other State and Federal Law (42CFR Part 2), which prohibits the recipient from making any further disclosures without specific written consent of the person to whom the information pertains. I understand that I am under no obligation to sign this authorization/consent and that my treatment will not be dependent on such. I may revoke this authorization/consent at any time with written or verbal notice to Valley Forge Medical Center and Hospital, except as to information already released in reliance on this authorization/consent. This authorization/consent expires (1) year from the date of discharge.

This consent expires one year from the date of signing.

A copy of this consent for has been offered to me: ☐ Accepted ☐ Declined

X _____ _____
Patient Signature Date/Time

X _____ _____
Staff Signature/Credentials Date/Time