



**ALLIED
SERVICES**
REHABILITATION HOSPITAL

475 Morgan Highway
Scranton, PA 18501
(570)348-1482
(570)341-4658

AUTHORIZATION FOR RELEASE OF HIV-RELATED INFORMATION

I hereby authorize Allied Services Rehabilitation Hospital to release any and all HIV-related information from the medical records of:

Patient's Name (please print)

This information is to be released to:

Person or organization

Address

for the purpose of _____. I understand that the information includes HIV-related information. The following portions of the record to be released

are: _____
Itemize portions of medical record and time period

I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for a period of ninety (90) days in order to effectuate the purposes for which it was given.

Date of Signature

Patient Signature

Witness

Signature of Responsible Party (when applicable only)
(Relationship to Patient)

Attention: Recipient of Information Protected by Pennsylvania Law

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.

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App. 6/91
revised 5/98, 3/03