Greater Reading Mental Health Alliance

Authorization to Disclose Protected Health Information

I,_____, _____, _____
Consumer's Name | MA ID# | Date of Birth

Hereby give my permission to the Greater Reading Mental Health Alliance to obtain information from:

_____ _____ _____
Name of Agency/Practitioner | Phone | Fax

_____ _____ _____
Address | City | State/Zip

This information is for the following purpose(s) of:_____

Diagnosis/ Assessment:_____

Your rights: I understand that I have the right to revoke this authorization at any time by giving notice in writing to the Greater Reading Mental Health Alliance (1234 Penn Ave., Wyomissing, PA. 19610), except to the extent that action has been taken in reliance of this signed authorization. I understand that I have the right to refuse to sign this authorization and the right to a copy of this authorization. I have read and/or had the information explained to me, and I understand it contents and give my authorization to use or disclose my protected health information as indicated above.

Effective Date:_____ Expiration Date:_____

Consumer Printed Name:_____

Consumer Signature and Date:_____

Witness Signature and Date:_____