MERCY HOUSE OF MEADVILLE, INC.
13180 Leslie Road, Suite 2
Meadville, PA 16335
Phone 814-337-6180 Fax 814-724-7681

PRIMARY CARE PHYSICIAN
REQUEST TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize Mercy House of Meadville, Inc. to release information from records of

(Client's Name)_____ Client's Date of Birth: _____

Social Security Number: _____ to my Primary Care Physician.

Dr. Name: _____ Phone #: _____

Purpose of release: _____

Specific information to be released:

_____

_____

_____

These records concern the time between _____ and _____.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent verbally or in writing, at any time. This consent will expire automatically one year from the date on which it is signed. Re-disclosure of any client information to other agencies is prohibited.

Signature of Client: _____

Printed name: _____ Date:_____

Signature of Witness: _____

Printed name: _____ Date:_____

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature: _____ (Therapist or Intake)

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42CFR Part 2). The Federal rules prohibit you from making any further disclosers unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of other medical 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 client.

- ☐ Client offered copy/Client Accepted
- ☐ Client offered copy/Client Refused