

**Consent to Disclose Personal Health Information
HIPAA Privacy Authorization Form**

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act - 45 C.F.R. Parts 160 and 164)

I, _____ (Print your name) authorize _____

(Print name of health information custodian and title) whose address is _____

to disclose the protected health information described below to **The Clerical Council for Family Affairs – PA Local District also known as CCFPPA and/or its assigned representatives, P.O. BOX 387, Conshohocken, PA 19428**

1. I hereby authorize the release of (check one box only) my or my dependents _____
(Print name of dependents) complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).
2. I hereby authorize the release of (check one box only) my or my dependents _____
(Print name of dependents) complete health record with the exception of the following information:
 Mental health records
 Communicable diseases (including HIV and AIDS)
 Alcohol/drug abuse treatment
 Other (please specify) _____
3. I understand the purpose for disclosing this personal health information to The Clerical Council for Family Affairs – PA Local District. I understand that I can refuse to sign this consent form.
4. This medical/mental health information may be used by the person/organization I authorize to receive this information for review of any application filed by me or by my current or former spouse with the Clerical Council for Family Affairs- PA Local District or other purposes as I may direct.
5. This authorization shall be in force and effect until the matter before the Clerical Council for Family Affairs- PA Local District is concluded.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
7. I understand the Clerical Council for Family Affairs- PA Local District retains all information and/or files in full confidentiality and shall not disclose the documents to any administrative tribunal or court of law. The Council will not release documents under any condition pursuant to the guidelines of ecclesiastical confidentiality and religious privilege.
8. I understand that at no time shall I compel or subpoena the records of the Clerical Council for Family Affairs- PA Local District relating to any matter I may have pending with them.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient