Chester Community Clinic
Widener University

# Authorization to Release Healthcare Information

Name:_____ Phone:_____

Date of Birth:_____

I authorize the Chester Community Clinic to release all healthcare information to the physician listed:

Physician name:_____ Phone:_____

Address:_____ City, State, Zip:_____

This authorization also applies to the following individuals:

Name:_____ Phone:_____

Address:_____ City, State, Zip:_____

Relationship:_____

Name:_____ Phone:_____

Address:_____ City, State, Zip:_____

Relationship:_____

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature: _____ Date:_____

Name (print):_____

This authorization expires upon discharge from services.