

Authorization for Disclosure of Healthcare Information

I hereby authorize _____ (physician's name) to release to the Berks County Tax Claim Bureau the Attending Physician Statement attached hereto. This Statement will be submitted to the Berks County Treasurer as part of my application to participate in the County's Hardship Program for the deferred payment of my delinquent real estate taxes.

I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS SPECIFIED ABOVE. I UNDERSTAND THAT THE INFORMATION DISCLOSED ACCORDING TO THIS AUTHORIZATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY LAW AND THE RECIPIENT OF MY HEALTH INFORMATION MAY POTENTIALLY REDISCLOSE IT. THIS AUTHORIZATION WILL BE VALID FOR 180 DAYS ONLY. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BY NOTIFYING THE PRIVACY CONTACT FOR THE PROVIDER THAT THIS REQUEST IS DIRECTED TO AND THE COUNTY TREASURER OF THE COUNTY OF BERKS, PENNSYLVANIA. THE EXCEPTION TO MY RIGHT TO REVOKE INCLUDES DISCLOSURES THAT WERE MADE PRIOR TO MY REVOCATION AND ANY AUTHORIZATION THAT WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE. I AUTHORIZE THAT A PHOTOCOPY OF THIS AUTHORIZATION BE ACCEPTED IN LIEU OF THE ORIGINAL.

Date: _____

Signature: _____

Guardian or Legal Representative: _____

Printed Name of Representative: _____

Date: _____