CVIM ID #:

Release Form

Section I

I, _____, give my permission for **Community Volunteers in Medicine** to share the information listed in Section II of this document with **Main Line Health and physicians participating in the Main Line Health Charity Care Program**.

Section II – Health Information

I would like to give the above healthcare organization permission to**:**

☑ **Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment for all conditions.**

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'**.**

At my request

Section IV – Duration of Authorization

This authorization to share my health information is valid for this episode of care at Main Line Health and with the physicians participating in the Main Line Health Charity Care program.

I understand that:

- This authorization may be revoked in writing at any time.
- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

Section V – Signature

_____

Signature:

_____ _____

Print your name: **DOB:**

If a person with legal authority to act an individual is completing this form's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____