

D&A, MH, or HIV-related Information cannot be used/disclosed in reliance on this form unless specified explicitly as such under Item 2.
D&A and HIV- related disclosures must be accompanied by disclosure statements required verbatim by federal and state laws.



AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION
[SEND/RECEIVE]

I, _____, authorize Bucks Villa, Inc. and its management agent, Family Service association of Bucks County (FSA) to use and/or disclose my protected health information only as described below:

1. This Authorization's **purpose** is as follows: To communicate information between the PRAC 811 program staff and the resident's medical case manager at Family Service Association of Bucks County.
2. This Authorization **covers** the following information about me: Name, Address, SSN, DOB, income, assets and medical, including HIV, information.
3. This Authorization **permits** FSA to release the covered information which it has in its possession.
FSA may release this information to the following person(s) or entity(ies):
Case Manager's Full and Proper Name/#:

_____ **Full Mailing Address:** _____

4. This Authorization **permits** the above-named person(s) or entity(ies) to disclose the covered information about me which is in their possession to FSA immediately upon FSA's request.
5. I understand that I have a **right to revoke** this Authorization at any time. To do so, I must revoke it in a written notification to FSA. I understand that FSA has a notification form for me to use if I wish to revoke this Authorization at any time before it expires. Revocation will be effective immediately upon FSA's receipt of proper notification. I may not revoke this Authorization to the extent that FSA has already relied upon it or if it was signed as a condition of obtaining insurance coverage.
6. In the absence of revocation, this Authorization **becomes effective** on (*Specify Date.*) _____ and **will expire** on (*Specify Date or Event*) _____

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7. FSA is instructed to prohibit **redisclosure** by parties receiving this information, but I understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy regulations provided to me by law.

 8. I understand that FSA may not require that I sign this Authorization in order to obtain treatment.

PENALTIES FOR MISUSING THIS CONSENT:

Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government. HUD, the PHA, and any owner (or any employee of HUD, the PHA, or the owner) may be subject to penalties for unauthorized disclosures or improper uses of information collected based on the consent form. Use of the information collected based on this verification form is restricted to the purposes cited above. Any person who knowingly or willfully requests, obtains, or discloses any information under false pretenses concerning an applicant or participant may be subject to a is demeanor and fined not more than \$5,000. Any applicant or participant affected by negligent disclosure of information may bring civil action for damages and seek other

relief, as may be appropriate, against the officer or employee of HUD, the PHA, or the owner responsible for the unauthorized disclosure or improper use.

I have read this Authorization, or had it explained to me, and I understand its contents.

FSA has given me a copy of this Authorization. Copy: Accepted Declined

Client's Signature: _____ **Witness' Signature:**

Date in Client's Handwriting _____ **Date in Witness' Handwriting:**
