



Consent to Release Medical Information

Last Name: _____ First Name: _____ Date of Birth: ____/____/____

I, _____, hereby authorize Family Health Center to disclose the following protected health information to: _____.

Information to be released:

- ☐ Any and all information ☐ Last year of complete chart record
☐ Billing information

Purpose for which disclosure is being made: (Please check one of the following)

- ☐ Attorney ☐ Doctor ☐ Insurance ☐ Personal ☐ Other _____

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

- ____ Drug/Alcohol abuse/treatment & diagnosis ____ Sexually Transmitted Disease
____ Mental Illness or Psychiatric diagnosis/treatment ____ HIV/AIDS diagnosis/treatment/testing

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed by this authorization. **There may be a charge for these copies.**

I understand that I may revoke this authorization at any time by notifying Family Health Center in writing, but if I do it will not have any affect on any actions Family Health Center took before they received the revocation.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or refen-al information.

Please initial ONE option below: (If no option is chosen this will be treated as a one-time request)

- ____ I understand that this authorization is valid for 1 year from the date signed **OR,**
____ I understand that this authorization is valid as a one-time request and if additional records need to be released I will need to sign another release of records request **OR,**
____ I understand that this authorization will not expire until I specify in writing an end date.

Signature of Patient or Patient Representative

Date