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Family Health Center
your medical home

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Authorization To Release Medical Information

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

Requesting Records From: Family Health Center

Release/Send Records To: _____

City: _____ State: ___ Phone #: _____ Fax #: _____

Information to be released:

[ ] Last 4 chart notes
[ ] Colonoscopy report & pathology
[ ] Mammogram & pathology
[ ] Pap Results
[ ] Other: _____
[ ] Current medication list
[ ] Last 4 lab results
[ ] Bone Density
[ ] Immunization record

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
_____Mental Illness or Psychiatric diagnosis/treatment
_____Sexually Transmitted Disease
_____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 referral 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.

_____ _____
Signature of Patient or Patient Representative Date

*Please provide documents to prove authority to sign on behalf of the patient.