Authorization for Use and/or Disclosure of Protected Health Information Form

(PLEASE FILL OUT COMPLETELY TO AVOID A DELAY IN PROCESSING)

FAMILY Health Source

DATE: _____ **DATE OF BIRTH:** _____/_____/_____

PATIENT'S NAME: First_____Middle_____ Last_____

PATIENT'S ADDRESS: _____

PHONE #: _____

I HEREBY AUTHORIZE _____

Address: _____**Phone #:** _____**Fax #:** _____

TO RELEASE MY MEDICAL RECORDS TO: **CHOOSE:** ❑**Paper** ($15 first 25 pages, .25 cents per addl. pg ❑ **CD** ($10 flat fee)

Person or Facility: _____**Phone #:**_____

Address:_____**Fax #:**_____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s) _____ _____ Pharmacy

_____ Other: (specify) _____ _____ Dental

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Legal _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Signature of Patient or if minor Legal Guardian | If minor, relationship to patient

_____ _____

Printed Name | Date

_____ _____

Witness (Must be signed by a witness) | Date

FOR OFFICE USE ONLY - MUST BE COMPLETED BY FHS STAFF

DATE PROCESSED: _____ BY: _____FEES COLLECTED $_____

MAILED ON: _____ FAXED ON: _____(confirmation received) PICKED UP BY: _____

ID PRESENTED: _____

Rev. 10/17/2018