AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION FROM FCFC

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____ **Year Last Seen:** _____ **Primary Care Physician:** _____

Reason for record(s) request:

_____Permanent Transfer _____Referral to Specialist _____Legal Investigation _____Personal
_____Disability Determination _____Insurance _____Workers Comp _____Other

Records to be disclosed to:

Name: _____
Address: _____
Phone: _____
Fax #: _____

Information to be released:

_____I do _____I do not authorize the release of information related to **HIV/AIDS, psychological or psychiatric conditions**, and treatment for **alcohol and / or drug abuse**.

Release the following records:

_____Last 2 yrs. medical records, generated by signed release, to include progress notes, labs and diagnostic results
_____Only some portion of medical records (be specific) _____.

_____Other _____.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Patients may revoke this authorization by writing a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. Except under limited circumstances, we will provide you with the access you request. We will respond to your request for access within 14 days from the time we receive this completed form. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed.

If you ask us to copy your health information, we may charge you $18.53 for up to the first 10 pages, and $0.85 for each page thereafter.

This authorization is valid for 1 year from date of signature unless otherwise indicated _____.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc)

NOTE: THE SIGNATURE OF THE PATIENT IS REQUIRED BY ALL PATIENTS 18 YEARS OF AGE OR OLDER.