



Friends of Family Health Center

501 S. Idaho St.
 La Habra, California 90631
 Phone: 562-690-0400 Fax: 562-690-3182

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

I authorize the disclosure of my personal health information to the persons/entities as described below. I understand this authorization is voluntary, and made to confirm my directions. I hereby give permission to Friends of Family Health Center to disclose my personal health information in the manner described herein.

Patient Name: (or other names used, maiden or alias)	Date of Birth	Social Security Number
Patient Address:	City, State, Zip Code	Telephone Number
Member/Medical Record Number	Group/Patient Number	Spouse's Name
I HEREBY AUTHORIZE (THOSE NAMED BELOW):		PROVIDE TO (THOSE NAMED BELOW):
Name of Provider/Practitioner		Name of Recipient
Name of Medical Facility		Name of Medical Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Telephone and Fax Number		Telephone and Fax Number

COPY/RELEASE THE FOLLOWING INFORMATION FROM MY RECORDS (CHECK ALL THAT APPLY & INITIAL ON THE LINE):

<input type="checkbox"/> History and physical examination _____	<input type="checkbox"/> Operative Reports _____	<input type="checkbox"/> Laboratory _____
<input type="checkbox"/> X-ray Films _____	<input type="checkbox"/> Pathology Reports _____	<input type="checkbox"/> X-Ray reports _____
<input type="checkbox"/> Immunizations _____	<input type="checkbox"/> Consultation _____	<input type="checkbox"/> Progress/Doctors Notes _____
<input type="checkbox"/> Alcohol & Drug Abuse Records _____ Date Range _____	<input type="checkbox"/> Hospital Records _____	<input type="checkbox"/> Pathology Slides _____
<input type="checkbox"/> HIV/AIDS Testing and Results _____ Date Range _____	<input type="checkbox"/> Discharge Summaries _____	<input type="checkbox"/> Other _____
	<input type="checkbox"/> ER/Urgent Care _____	<input type="checkbox"/> Mental Health _____ Date Range _____
	<input type="checkbox"/> Entire file _____	

THE USE OF MY RECORDS IS LIMITED TO THE FOLLOWING (CHECK ONE):

<input type="checkbox"/> Self	<input type="checkbox"/> Continuing HealthCare	<input type="checkbox"/> Worker's Compensation
<input type="checkbox"/> Other insurance claim _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Limits: _____

AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR:

- The above named patient
- The legal representative of the above-named minor patient
- The legal representative of the above-named incompetent patient (must provide legal documentation)
- The beneficiary of personal representative of the above-named patient who is deceased (must provide legal documentation)

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received Yes No

I have been made aware that fees for processing this authorization may apply. I also acknowledge that said fees might be my responsibility.

Patient Initials _____

_____	_____	_____
Date	Signature	Witness
_____	_____	_____
PRINT Name	Address (if other than patient)	City/State/Zip Code

