Friends of Family Health Center

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. I understand that I have a right to receive a copy off this authorization upon my request.

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):

☐ History and physical examination _____	☐ Operative Reports _____	☐ Laboratory _____
☐ X-ray Films _____	☐ Pathology Reports _____	☐ X-Ray reports _____
☐ Immunizations _____	☐ Consultation _____	☐ Progress/Doctors Notes _____
☐ Alcohol & Drug Abuse Records _____	☐ Hospital Records _____	☐ Pathology Slides _____
Date Range_____	☐ Discharge Summaries _____	☐ Other _____
☐ HIV/AIDS Testing and Results_____	☐ ER/Urgent Care_____	☐ Mental Health_____
Date Range_____	☐ Entire file _____	Date Range_____

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

☐ Self	☐ Continuing HealthCare	☐ Worker's Compensation
☐ Other insurance claim _____	☐ Other: _____	☐ 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)
- **___ 1 year after signed ___2 years after signed ___ on this date: _____ .**

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

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