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

All fields marked with an asterisk (*) are required.

*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

***REQUIRED* 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_____

***REQUIRED* 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

Revised 7/13/20