Authorization for Release of Information (From FHCA)

FAMILY HEALTHCARE ASSOCIATES

I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider; the released information may no longer be protected by federal and state privacy regulations.

Patient Name (please print) _____ Date of Birth _____ Social Security Number _____

Patient Address (City, State and Zip) _____ Phone Number _____

Specific Date(s) of Service (if known) _____ ☐ All Dates of Service

Information to be released: (Check all that apply)

☐ **Complete Medical Records** ☐ Radiology Reports & Films ☐ Registration Record ☐ Billing Records

☐ Visits & Encounters ☐ Laboratory Reports ☐ Consultation Reports ☐ Emergency Room

☐ Operative Records ☐ Other: _____

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be **released to:**

Category: ☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other _____

Name of Person or Entity (please print) _____ Phone Number _____

Address (City, State, and Zip) _____ Fax Number _____

Delivery Method: ☐ Mailing Address ☐ Fax ☐ Pick-Up Records ☐ Other _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____(Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient, Parent, or Legal Guardian _____ Date _____

Print Name of Patient, Parent, or Legal Guardian _____

Relationship to Patient _____ or Legal Authority (Attach Supporting Documentation) _____