FHC – Authorization Form

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Patient ____ Date of Birth ____________

I authorize ___________________________ to release to ____________________________________

The following information:

___ Entire medical record

___ Other ____________________________

Records covering services provided
From dates __________ to ________________
___ All records between these dates
___ Lab tests
___ Discharge Summary
___ Consultation Reports
___ Imaging Reports
___ Other ____________________________

The purpose of this disclosure is

___ Coordination of care
___ Legal case
___ Requested by Patient, or guardian/parent
___ Other ___________________________________

1) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2) I understand that the party receiving my information might not be subject to HIPAA and might be allowed to disclose this information.
3) The facility releasing the records does not require that I sign this authorization in order to receive services.

Expiration Date:

___ 90 days from date signed
___ other date: _______________

Patient Signature: ____ Date: _____________

If signed by someone other than the Patient:

Print Name____
Authority to sign: ___ Parent or Guardian
____ Appointed by Patient as HIPAA Personal Representative
____ Other ____________________________________

For staff use (complete the following steps and indicate by a check. Name of Staff Person _________________)
___ Copy of signed authorization given to Patient / Parent / Guardian
___ Copy of records released given to patient / Parent / Guardian (if requested)
___ Revocation received on __________ and acted upon.

Approved by: ____ Date: ____________