Family Care Center
Behavioral Health Services

HIPAA Compliant Authorization to Release Medical Information

(Used to Request Records from an Outside Provider)

Patient Information:

Patient Name: _____ DOB: _____

Address: _____

Phone Number: _____ Email Address: _____

Information Requested

1. I hereby request that _____ provide Family Care Center with access to my Protected Health Information as checked below for the period of _____ to _____.

☐ Complete Health Record	☐ Minimum Data Set
☐ Activity Documentation	☐ Medication and treatment records
☐ Admission/re-admission Documents	☐ Nursing Documentation
☐ Advance Directives	☐ Progress Notes
☐ Assessments, flowsheets	☐ Reports (Lab, x-ray, other)
☐ Care Plan	☐ Test results
☐ Informed Consent	☐ History, exams, and other records

☐ Other (please describe): _____

2. The information identified above should be sent to the following individual(s) at Family Care Center:

Recipient 1.

Name _____

Address _____

Phone Number _____

Fax Number _____

Email _____

Recipient 2.

Name _____

Address _____

Phone Number _____

Fax Number _____

Email _____

3. Purpose: The information requested and described on the previous page will be used for the following purpose(s):

   ☐ Initiated at the request of the patient

   ☐ Sharing with other healthcare providers involved in patient's care

   ☐ Other (Describe): _____

4. Please complete the check boxes below even if the categories do not necessarily apply to the patient's records.

   Check One

   I ☐ Do ☐ Do not want information on **Mental Health** to be released.

   I ☐ Do ☐ Do not want information on **HIV Tests and Related Information** to be released.

   I ☐ Do ☐ Do not want information about **Alcohol and/or Substance Abuse** to be released.

   I ☐ Do ☐ Do not want information about **Communicable Diseases** to be released.

   Please confirm that you made a selection for each protected information category above. If this form is incomplete, it may not be processed.

Authorization Statements/Signatures

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation the individual(s) and/or organization named in this Release. I understand that the revocation will not apply to information that has already been released in response to this authorization.

3. Unless I specify differently, this authorization will expire 12 months from the signature date.

Required Signatures

Signature of Patient:		Date:
Patient Name:		
Signature of Personal Representative: (if applicable):		Date:
Personal Representative Name:		

* If a personal representative executes this authorization, then the authorization must contain a description of the representative's authority to act for the patient (e.g.- "parent" or "guardian ad litem")