



**Authorization for Release of Confidential Health Information**

Patient name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**I hereby authorize to release protected health information regarding the above-named person to be exchanged**

**TO:** Person/Institution/Other: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone number: \_\_\_\_\_

**I authorize the release of information pertaining to the following time periods:**

From date(s): \_\_\_\_\_ To date(s): \_\_\_\_\_

**The following types of information to be disclosed are as follows:**

- |  |  |
|--|--|
| <input type="checkbox"/> History and physical examination        | <input type="checkbox"/> Alcohol/substance abuse                                 |
| <input type="checkbox"/> Consultation reports                    | <input type="checkbox"/> HIV/AIDS  |
| <input type="checkbox"/> Progress notes                          | <input type="checkbox"/> Rehab Records   |
| <input type="checkbox"/> Operative reports                       | <input type="checkbox"/> Psychiatric outpatient notes (pre/post hospitalization) |
| <input type="checkbox"/> Diagnostic reports (labs, x-rays, etc.) | <input type="checkbox"/> Psychiatric Evaluation                                  |
| <input type="checkbox"/> Physician discharge                     | <input type="checkbox"/> Behavior Plans  |
| <input type="checkbox"/> Emergency department record             | <input type="checkbox"/> Mental health record                                    |
| <input type="checkbox"/> Social history                          | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Pathology reports                       |  |
| <input type="checkbox"/> Developmental disability records        |  |

**Highly CONFIDENTIAL items MUST be checked off to be EXCLUDED from this disclosure:**

- |  |   |
|--|---|
| <input type="checkbox"/> HIV/AIDS                            | <input type="checkbox"/> Child Abuse    |
| <input type="checkbox"/> Developmental Disabilities          | <input type="checkbox"/> Sexual Assault |
| <input type="checkbox"/> Drug/alcohol diagnosis, treatment   | <input type="checkbox"/> Pregnancy      |
| <input type="checkbox"/> Genetic testing information/records |   |

**The purpose(s) of this authorization is (are):** \_\_\_\_\_

**This authorization expires (date):** \_\_\_\_\_. **If not specified, this release will expire 1 year after the date of signature (date):** \_\_\_\_\_.

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize **Family Care Associates** to use or disclose my health information in the manner described above.

**Printed name of patient, legal guardian, or authorized agent:** \_\_\_\_\_

**Signature of patient or legal guardian, or authorized agent:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Staff signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_