Patients First Medical Clinic

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

For the **purpose** of: ☐ Personal (at the request of the patient) ☐ Treatment ☐ Workers Comp. ☐Insurance

☐ Legal ☐ Government ☐ Other (specify) _____

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **PATIENTS FIRST MEDICAL CLINIC**

to release health care information of the patient named above to:

Name: _____ Phone:

Address: _____ Fax:

City: _____ State: _____ Zip Code:

For date(s) of service:_____ to _____

This request and authorization applies to:

☐ Emergency Reports ☐ Consultation ☐ Pathology Reports ☐ History and Physical ☐ Discharge Summary

☐ Laboratory Reports ☐ Radiology reports ☐ Clinic Reports ☐ Radiology Films ☐ Problem/ Medication Lists

☐ Immunization Chart ☐ EKG ☐ Other

I acknowledge that the data to be released MAY INCLUDE material that is protected by Federal Law. My initials and my signature below authorize release of the following type of information.

Terms:
____ I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration and Right to Revoke Authorization:
____ Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to PFMC. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following **date or event:**_____

Re-Disclosure:
____ I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

HIPAA COMPLIANT

Printed Name:_____ Signature:_____
Relationship to Patient:_____ Date:_____
Witness:_____ Date:_____

To be completed by PFMC Staff (document all requests)
Date Received: _____ Date Completed_____
Materials Sent_____
Completed By: _____

(Rev. 12/13)