FAMILY MEDICAL CENTER

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION

Name: _____

Other Names Used: _____

Address: _____

City, State, Zip: _____

Birthdate: _____

Telephone Number: _____

COPIES RELEASED FROM

Name: _____

Address: _____

City, State, Zip: _____

COPIES RELEASED TO

Name: _____

Address: _____

City, State, Zip: _____

GENERAL INFORMATION

1. Type/Extent of Information

☐ All Records

☐ Selected Records Only (specific dates)

_____

2. Purpose/Need

☐ Further Treatment
☐ Insurance Reasons
☐ Disability
☐ Changing Physicians
☐ Other: _____

3. Specific Information (please list)

_____

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:

I specifically consent to the release of data and information relating to: (check all that apply)

☐ Substance Abuse (Alcohol/D.A.)
☐ Mental Health (including psychological evaluation and treatment)
☐ HIV Related Information (AIDS related testing)

Patient Signature: _____
Date: _____

NOTICE: With respect to any substance abuse treatment information, mental health records, and/or communicable disease related information protected by State and Federal law and released pursuant to this authorization, the recipient understands that it is prohibited from making any further disclosure of this information without the specific written consent of the patient, or as otherwise permitted by law/regulation.

This authorization shall be considered invalid after 6 months or 60 days with respect to State and Federally protected records from the date of signature.

I may revoke this authorization at any time by providing written notice of revocation. However, I may not revoke the authorization retroactively for information already released.

Patient Signature: _____
Date: _____

If patient is unable to consent by reason of age or other factors, state reasons:

_____

Legally Authorized Representative:

_____

Relationship: _____

Witness: _____