FAMILY HEALTH CENTER

Effective 7/2018

1027 Washington Avenue, Suite B
Vincennes, IN 47591

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient ______________________ Previous Names, If Applicable ______________________

Address ______________________ Date of Birth ______________________

City/State/Zip Code ______________________ Daytime Telephone Number ______________________

SEND INFORMATION TO:

Provider Name/Organization: Family Health Center

Address: 1027 Washington Avenue, Suite B

Vincennes, IN 47591

Phone #: (812) 494-7500 Fax #: (812) 494-7600

INFORMATION TO BE RELEASED FROM:

Provider Name/Organization: ______________________

Phone #: ______________________ Fax #: ______________________

PURPOSE OF DISCLOSURE:

☐ Continuing Care ☐ Self ☐ Other ______________________(must complete)

INFORMATION TO BE DISCLOSED:

Dates of Service: ______________________

☐ Clinical Summary
☐ History & Physical
☐ Consultation Report
☐ Operative Report: ________________
☐ Entire Record
☐ Laboratory Reports: ______________________
☐ Pathology Report: ______________________
☐ Radiology Reports: ______________________
☐ Emergency Services Report: ______________________
☐ Other (Please Specify): ______________________

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for Instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA Rule of 1996. **Expiration Date:** __________ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

DRUG AND/OR ALCOHOL, ABUSE AND/OR HIV/AIDS, MENTAL HEALTH RECORD RELEASE:

If my medical or billing record contains the above I have indicated below that the following can be released:

Drug and/or Alcohol	☐ Yes	☐ No
HIV/AIDS Testing	☐ Yes	☐ No
STD Testing	☐ Yes	☐ No
Mental Health Treatment	☐ Yes	☐ No

______________________ ______________________ ______________________
(Signature of patient or representative) **(Relationship to Patient)** **(Date)**

TO BE COMPLETED BY HEALTH CENTER PERSONNEL:

MRUN:____________________

ID Checked ☐ **Signature** ☐ **Photo**

Person Checking ID _________

Request completed: ☐ **Yes** ☐ **No**
Person taking request: ________
Person completing request: ________
Pages Copied _________