Authorization for Release of Protected Health Information

Patient Name: _____**DOB:** _____

I authorize the Family Care Center to use or disclose my health information as described below. 1. Type of Information: The type of information to be used or disclosed is as follows:

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

2. Recipient Information: The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name _____

Address _____

Phone Number _____

Fax Number _____

Email _____

Name _____

Address _____

Phone Number _____

Fax Number _____

Email _____

3. Purpose of use/disclosure: The information described on the previous page will be used for the following purpose(s):

- ☐ Initiated at the request of the patient
- ☐ My personal records
- ☐ Sharing with other healthcare providers
- ☐ Other (Describe): _____

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 to a Family Care Center staff member. 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 on _____.

4. I understand that the Family Care Center will not condition the provision of treatment nor payment on the provision of this authorization.

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

<u>Revocation Information</u>

Date of Revocation:	
HIPAA Compliance Officer Initials	

Distribution: *Original to patient's Health Record, copy to patient*