RELEASE OF MEDICAL INFORMATION

HIPPA Compliant

(All lines must be completed before the records can be released.)

I, _____, hereby authorize the release of the following information:

(Please specify only information required, not "All Records".)

To include records dated from _____ to _____.

- ☐ Gyn/PAP records (past ____ yrs)
- ☐ Immunization/pediatric records
- ☐ Last 3 visits: _____
- ☐ Lab/x-ray reports - date: _____
- ☐ Medication List: _____
- ☐ Information related to specific problem: _____
- ☐ Drug/alcohol/STD/HIV/mental health info **
- ☐ Other:_____

The requested information is released for the following purpose and for that purpose only:

☐ Ongoing treatment ☐ Insurance requested ☐ Personal ☐ Other:_____

From: _____

(Name of Doctor, Clinic, Hospital or Indivudual)

Address/Fax: _____

To: _____

(Name of Doctor, Clinic, Hospital or Indivudual)

Address/Fax: _____

Name of patient at time of treatment:_____ Birth Date:_____

Signed: _____ Date: _____

(patient, parent, or legal guardian)

Print Name:_____ Relationship to patient: _____

Witness: _____

This consent will expire on _____ or 60 days after the date above.

Received by The Family Health Center, P.C. on _____ by _____

Fees for copying records released directly patient:

One time courtesy copy of current records up to 10 pages=No Charge

All additional copies after that are charged 1st 25 pages=$25.00, each additional page =$0.50.

Fee for copying records released to a legal firm:

First 25 pages =$25.00, each assitional page =$0.50 each.

** I acknowledge that data marked with ** may include materials that are protected by Federal law. My signature above authorizes the release of this information. This consent is subject to revocation at any time except to the extent that the department which is to make the disclosure has already taken action in reliance on it.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.