FAMILY & INDUSTRIAL MEDICAL CENTER

47 SANTA ROSA STREET
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AUTHORIZATION TO RELEASE PROTECTED HEALTH IN FORMATION (PHI)

I authorize the Family & Industrial Medical Center to Release / Request a copy of my Protected Health Information described below:

❑ Release **To:**	❑ Request **From:**
Name:_____	Name:_____
Address:_____	Address:_____
Phone/Fax:_____	Phone/Fax:_____

***For the purpose of:**

❑ Continuing Medical Care ❑ Transfer of Care ❑ Legal Purposes

❑ Social Security/Disability ❑ School ❑ Patient's Personal Records

❑ Other (specify)_____

***This information is limited to the following type and amount of information. (Use dates where appropriate).**

❑ Progress Notes ❑ Consultation Reports ❑ Immunization Records

❑ Laboratory, Pathology Reports from/to_____ ❑ All records for the last 2 years

❑ Radiology Reports/Imaging Reports From/to_____ ❑ All records for transfer of care

❑ Medical Records relating to injury X-rays_____ ❑ Other Job placement Physical Drug Screen_____

****DISCLOSURES REOUIRING SPECIAL CONSENT****

*My signature below specifically authorizes the release of health care information relating to the testing, diagnosis or treatment for:

❑ **HIV/AIDS** ❑ **Psychiatric Records**

❑ **Sexually Transmitted Disease Information** ❑ **Alcohol and/or Drug Abuse/Treatment Records**

Patient/Patient Representative:_____ Relationship (if not patient):_____

* I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____

* **If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months from the signed date.**

* Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

_____/___/_____ _____(____)_____

Print Patient Name Date of Birth Patient Signature Phone Number

_____ _____/____/_____

Print Name of Authorized Representative Signature of Authorized Representative **Signature Date**