Family Care Center | Transforming Behavioral Health

Patient Authorization to Disclose Protected Health Information (PHI)

Section 1. Patient Information

Last Name: First Name: Date of Birth:

Phone Number: Email Address:

Section 2. Authorization to Release PHI.

I hereby authorize the Family Care Center (FCC) to disclose/release my Protected Health Information to the organization, agency, or person named below:

Organization, Agency, or Individual:

Address: Email:

City, State, Zip Fax Number:

Section 3. Information to Be Released.

All Health Records: ☐ Treatment Summary: ☐ Discharge Summary: ☐

Medication Records: ☐ Assessment/Test Results: ☐ Lab Work: ☐

Patient Portal Access (For making payments and communicating with providers. Portal does not contain medical records.) ☐

Treatment Dates to Be Released:

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Section 4. Authorization.

Authorization: I certify that this request is made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing to the Release of Information office. If I have authorized the release of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy of fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Privacy Officer at (888)281-1060.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire one-year from the date hereof, unless a different date is specified here: _____.

Acknowledgment: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug, or alcohol abuse and/or alcoholism.

SIGNATURE: _____ **DATE**: _____
Patient (Parent or Legal Guardian)

Relationship (if other than patient): _____

Printed Name of individual signing on behalf of patient: _____

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