



Release of Information Authorization for Medical Records

I, _____, _____, hereby authorize
(First and Last Name of Patient) (Date of Birth)

HealthFirst Family Care Center to use or disclose my health information as indicated (*only check one*)

Provide information to: Obtain Information from: Exchange (Verbal) Information with:

Name/Agency: _____ Address: _____

Fax #: _____ Phone #: _____

Date(s) to be obtained/released records: From: _____ To: _____

Information being requested for release: (please check the appropriate items)

- | | |
|---|--|
| <input type="checkbox"/> Medical, diagnostic, testing, and treatment information | <input type="checkbox"/> Medication list (including prior authorization documents) |
| <input type="checkbox"/> Current Prenatal records, copies of all lab and imaging | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Sexually transmitted disease (Release to include sensitive information such as HIV results and treatment) | <input type="checkbox"/> Imaging Results |
| <input type="checkbox"/> Immunization records, and/or <input type="checkbox"/> Growth chart | <input type="checkbox"/> Other (Specify): _____ |

Reason for Disclosure: (Please check the appropriate item)

- Transferring care to another physician School Legal For personal records
 Other (Specify): _____

Methods of Disclosure Authorized: Fax, written, phone conversation, in-person and/or e-mail.

- I understand that this authorization will expire one year from the signed date. A photocopy of this form will be considered as valid as the original.
- I may inspect this health information before it is disclosed by making an appointment to review my record.
- I understand my refusal to sign this authorization will not affect my right to obtain present or future treatment except where the disclosure of the information is necessary for the treatment.
- I may withdraw my authorization by completing another form. This withdrawal will be effective on the date of signature except to the extent action has already been taken upon it.

Signature of Patient/Guardian/Parent

Date

If you are a parent or legal guardian, please print your full name: _____

Please note: Mental Health notes, Psychotherapy notes, and drug and alcohol related notes (SUD) require a separate consent form for these records to be released outside of HealthFirst Family Care Center.