



Authorization to Disclose Protected Health Information

Information Requested From:

Name of Person or Entity: \_\_\_\_\_

Address of Person or Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Release Information To:

Name of Person or Entity: \_\_\_\_\_

Address of Person or Entity: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

I hereby authorize the disclosure of information checked below from the records of:

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

This Authorization covers the following time periods:

- Insert Dates to All past, present and future periods:

[Insert Dates]

- I authorize the disclosure of all my Protected Health Information for the above time period (which may include information about mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

- I authorize the disclosure of all my Protected Health Information for the above time period except as noted below:

- Do not disclose mental health records
Do not disclose communicable disease records (including HIV and AIDS)
Do not disclose alcohol/drug abuse treatment records
Do not disclose other records (identify):

The purpose of this authorization is: Continued Care Insurance/Disability Litigation Personal Reasons

Other

This Authorization shall be in force and effect until, at which time this Authorization expires.

I understand that I have the right to revoke this Authorization at any time by submitting a written request to First Care Clinic, Inc., except to the extent that action has been taken in reliance on it.

I understand that my treatment will not be conditioned on whether I sign this Authorization.

I understand that information disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Legal Guardian if patient is under 18

Date

Print Name of Patient or Legal Guardian if patient is under 18

Relationship to Patient