FIRST care CLINIC

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:

☐ _____ to _____ ☐ All past, present and future periods:
[Insert Dates]

a. ☐ 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

b. ☐ I authorize the disclosure of **all my Protected Health Information for the above time period <u>except</u> as noted below:**
- ☐ Do <u>not</u> disclose mental health records
- ☐ Do <u>not</u> disclose communicable disease records (including HIV and AIDS)
- ☐ Do <u>not</u> disclose alcohol/drug abuse treatment records
- ☐ Do <u>not</u> 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.
[Date or Event]

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