

**Authorization to Release Protected Health Information**

I understand that if the person(s) and or organizations(s) listed below are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standard, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards, and my health information may be re-disclosed without obtaining my authorization.

This authorization will automatically expire one year from date of signature or until \_\_\_\_, 20\_\_\_\_. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on the actions they took before they received the revocation.

Any refusal to sign this form will not affect my ability to obtain treatment, payment or my eligibility for benefits. I may request to inspect or copy the health information to be used or disclosed. This release is not valid if it does not contain the patient signature.

**Patient Information:**

First Name:		Middle Initial:		Last Name:	
Previous Name:		Birthdate:		Daytime Phone Number:	
Street Address:		City:		State:	Zip:

**Release Information From:**

Name:	
Street Address/P.O. Box:	
City, State, Zip Code:	
Phone Number:	Fax Number:

**Send Information To:** Upcoming Appt. Date \_\_\_\_\_

Name:	
Street Address/P.O. Box:	
City, State, Zip Code:	
Phone Number:	Fax Number:

**Purpose of Release:**

- Continuation of Care   
  Transferring Care   
  Legal   
  Claims/Insurance   
  Personal   
  Other

**Medical Information to be Released: (Limited to 2 years of information unless otherwise specified)**

- Office Notes   
  Immunizations   
  Physical Therapy   
  Pathology   
  Lab   
  X-Ray Reports  
 X-Ray Images: Include date, body part, exam types: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Specific Authorization for Release of Information Protected By State or Federal Law**

***Please Initial Beside Any Category you DO NOT want to be Released***

- \_\_\_ Behavioral Health Services/Psychiatric Care/Mental Health  
 \_\_\_ Treatment for alcohol and/or drug abuse  
 \_\_\_ Genetic Information/Testing  
 \_\_\_ HIV-related information (including AIDS and related testing)

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

**Relationship, if not patient:** \_\_\_\_\_. Legal documentation is required supporting his/her authority to act on a patient's behalf. Photo identification is requested for all hand carry release of information requests. Facsimile reproductions of the signature are acceptable.

*Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. McFarland Clinic has partnered with Datavant to process requests for records. Datavant may directly send you a bill for your request for records.*