McFarland Clinic

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 ☐X-Ray Reports ☐X-Ray Images ☐Lab ☐Pathology
☐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.

If additional information is needed please contact McFarland Clinic Release of Information.

For Clinic Use

Medical Record Number _____ Processed by _____ Date Completed _____

09/2018