McFarland Clinic

Request 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:

_____ _____
Name Date of Birth

_____
Previous Name

_____
Street Address City State Zip Code

_____
Daytime Phone Number

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

Please Change My Primary Care Provider To: _____

Medical Information To Be Released: (Limited to 2 years of information unless otherwise specified)

___ Office Notes ___ Lab ___ Pathology ___ X-Ray Reports ___ X-Ray, images
___ EKG ___ OB Flow Sheet ___ Physical Therapy ___ Immunizations ___ Cardiovascular images
___ Billing Information ___ Other - Specify_____

For date(s) of treatment or condition

_____

The information disclosed may include matters regarding mental health/depression, alcohol or drug abuse, infectious diseases, including HIV and genetic testing information. Refusal to consent to release information will result in such confidential records not being released.

If you do not wish such information to be released, state information to be excluded: _____

Purpose of Release: _X_ Patient Request

_____ _____
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 will be 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.
Please contact McFarland Clinic if additional information is needed.

For Clinic Use

Medical Record Number _____ Processed by _____ Date Completed _____