FAMILY MEDICAL CARE
COMMUNITY HEALTH CENTER

Medical Records

Authorization For Use and Disclosure of Health Information

Patient's Name: _____

Date of Birth: _____ **Phone #:** _____

I authorize (**Name of provider/facility releasing records**): _____
Address: _____
Phone: _____ **Fax:** _____

to release to **(Name of provider/person receiving records):** _____
Address: _____
Phone: _____ **Fax:** _____

the following information: **Date(s) of Service:** _____
☐ **All Records** ☐ **Testing Results** ☐ **Prenatals** ☐ **Behavioral Health**
☐ **Other:** _____

I authorize all information which may be contained in my medical records pertaining to chemical dependency and/or AIDS/HIV-related illness/testing to* *(check one):*** ☐ ***be released*** ☐***not be released***

The recipient may use my health information only for the following purpose(s) ***(Must check at least one)***:
☐ **Continued Care** ☐ **Transferring Care** ☐ **Personal Use** ☐ **Attorney Review**
☐ **Other:** _____

EXPIRATION: The authorization shall become effective immediately and shall remain in effect for **90 days** from the date of signing.

RESTRICTIONS: Family Medical Care Community Health Center only releases records that are generated by *our* providers. Any information disclosed as per this authorization may be re-disclosed by the entity receiving the information. It may no longer be protected by federal or state laws.

YOUR RIGHTS:

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:
  Family Medical Care, Attn: Medical Records Dept., 3158 West Street, Weirton, WV 26062
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization (required if authorization requested for the provider's use or disclosure of health information).
- ***I understand that if I do not fill out this authorization form completely with all needed information, this will delay the exchange of medical records.***

SIGNATURE:

_____ _____
Signature (Patient/Representative) *Date*

_____ _____
Print Name (if signed by other than patient, also list relationship) *Name of CHANGE, Inc. Representative*