FAMILY PRACTICE CENTER PC
www.fpcdoctors.com

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

PATIENT NAME:	**DOB:**	**PHONE:**
PATIENT ADDRESS:		
ID Number (If applicable): #		
NAME/ADDRESS OF ORGANIZATION PROVIDING INFORMATION **PHONE:** **FAX:**	**NAME/ADDRESS OF ORGANIZATION RECEIVING INFORMATION:** **PHONE:** **FAX:**	
Specific Description of Information Disclosed		

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials:_____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;

Initials:_____ drug and/or alcohol diagnosis, treatment, test results and reports and referral information;

Initials:_____ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information;

Initials:_____ reproductive health information (including venereal disease information);

Initials:_____ genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Disclosure:

You must read and initial the following statements:

1. I understand this Authorization will expire on _____/_____/_____ (DD/MM/YR) or on the following event: Termination of the Physician/Patient Relationship. **Initials:** _____

2. I understand that I may revoke this Authorization at any time by notifying this Practice's Privacy Officer in writing, but if I do, it will not have any effect on any actions this Practice took before they received the revocation. **Initials**: _____

Signature of Patient or Representative	Relationship to Patient	Date
Witness	Date	

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

☐ N/A. If this Authorization is for marketing purposes, remuneration is / is not involved (Provider circle one).