Family Health Care

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

AUTHORIZATION TO RELEASE INFORMATION

Ciox has been contracted to copy all medical records. A copying charge maybe accessed up to $25 plus taxes and actual postage.

I, the undersigned, hereby authorize

_____
Organization Name Address Phone Number

its Administrator or designee of the Health Information Services Department to release information contained in my patient medical records. This release includes release of records to a care management organization who works in partnership with Family Health Care to improve my patient experience.

☐ Check box if this authorization of records release includes:

Release of information concerning treatment by my medical provider, of drug or alcohol abuse, drug related conditions, psychiatric/psychological conditions, or infectious disease (including Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), or AIDS Related Complex (ARC) information.)
Notice - This release of information authorization does not include behavioral health records or treatment for mental health or substance abuse by a behavioral health provider. *See* FAMILY HEALTH CARE BEHAVIORAL HEALTH CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION form, which is required for this protected information to be released.

Failure to provide all information requested may legally invalidate this authorization.

Please send the following: Problem List, Full Medication List, Last Wellness Visit, last two Clinic Visits, Lab Results for last year, any Colonoscopy reports with Pathology, last two Pap Smear Pathology/Microbiology reports, last two Mammogram results, Immunization Record, Dental X-ray and chart notes.

The above information is to be forwarded to: _____

Name of Organization or Title of Person: _____

Street Address: _____

City, State and Zip Code: _____

PLEASE SHARE REASON FOR RELEASE OF RECORDS: _____

This statement must be signed and dated, and is subject to written revocation at any time except in those circumstances in which the clinic has taken certain actions prior to revocation. This authorization will expire in ninety (90) days from the date of signing or otherwise by my choice, in which case this consent will expire on: _____

I hereby state that I have read and fully understand the above statements. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above. I understand that I may refuse to sign this authorization and that my health care cannot be conditioned upon signing this authorization. I may inspect or request a copy of information disclosed under this authorization.
I understand that if the person or entity that receives the information is not a health care provider or a health plan that is covered by federal privacy regulations (HIPAA), the information described above may be re-disclosed and no longer protected by these regulations.

This information is disclosed in accordance with Federal Confidentiality Rules (42 CFR Part 2), Section 748 of Michigan.

Patient Name:_____ DOB: _____

Address: _____

City/State Zip: _____

Phone: _____

Patient Signature:_____ Date: _____

Witness Signature:_____ Date: _____

(Witness required)

Relationship to patient if under 18 years of age, or unable to sign: _____

Copies made and released by:_____ Date: _____