AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Information to be disclosed from the record of:

Name of Patient: ______________________________Other Name used: ____________

Date of Birth: ____________________Telephone number: ____________________

Patient ID Number:________________(Optional)

I hereby authorize:	**To release to:**
______________________________ Persons/Organizations	______________________________ Persons/Organizations
______________________________ Address-Street	______________________________ Address-Street
______________________________ City, State, Zip	______________________________ City, State, Zip Fax number:

Type of Release Requested: (15 days for patient requests and 30 days for all other requests)

☐ Records burned to a CD
FHCN will not include mental health treatment information, HIV test results, genetic information, and alcohol/drug treatment information unless the applicable box or boxes are checked.

☐ Paper Copies
FHCN will not include mental health treatment information, HIV test results, genetic information, and alcohol/drug treatment information unless the applicable box or boxes are checked.

The following information may be released (Check all that apply)

☐ Last two years of medical records
☐ Last seven years of medical records
☐ All medical records available (For Fresno facilities, only records from Nov 1, 2014 forward.)
☐ Only the following dates/types of health information: ____________________________
☐ All dental history or dental condition and dental treatment received
☐ Family HealthCare Network Pharmacy/Prescription Records

I specifically authorize release of the following information (Check all that apply)

☐ Mental Health treatment information ☐ HIV test results
☐ Alcohol/drug treatment information ☐ Genetic information

Purpose of Requested Use or Disclosure/Reason for Transfer

☐ Moving Out of Area	☐ Insurance
☐ Personal Request	☐ School
☐ Continuity of Care	☐ Case Management of Outside Organization
☐ Transfer of Care to Another Provider:	☐ Other:
(specify reason): ______________________	(specify reason): ______________________

My Rights:
I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use and disclosure of. I may revoke this authorization at any time, but I must do so in writing, signed by me or on my behalf, and submit it to the following address:

Family HealthCare Network
Health Records Department
305 E Center Avenue
Visalia, CA 93291
Phone 559-737-4706
Fax 559-737-4931

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization.

Expiration: This authorization expires (insert date or describe event):________________________
(If date is blank, authorization expires one year from signature date of the request).

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure may no longer be protected by federal confidentiality law (HIPAA). However, under California law, the requestor may not further disclose the health information unless written authorization is received or as specifically required or permitted by law.

Signature: ____Date__________________Time________AM/PM
(Patient/parent/ legal representative)
If signed by other than the patient, state your legal relationship to the patient: __________________

Print Name: ____
(Parent/guardian, legal representative)

Witness/FHCN Staff Signature ____
(First initial, full last name and title)