Family HealthCare NETWORK

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 (staff use only):_____

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

Method of Release:

☐ Records burned to a CD

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

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

☐ The last two years of medical records

☐ The last seven years of medical records

☐ All health information pertaining to my medical, **mental (specific authorization required)**, or physical condition and treatment received. (For Fresno Ambulatory Care Center, Surgical Services, or Disease Management Services, 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 the release of the following information (Check all that apply)

☐ Mental Health treatment information

☐ Genetic information

☐ Alcohol/drug treatment information

☐ HIV test results (For Fresno Specialty Services, Ryan White/ HIV Clinic, only records from June 25, 2018, to June 29, 2023.)

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, 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
409 N Bridge St
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 the date is blank, authorization expires one year from the 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 someone 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)