McFarland Clinic PC

Authorization to Release Protected Health Information

I understand that if the person(s) and or organizations(s) listed below are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standard, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards, and my health information may be re-disclosed without obtaining my authorization.

This authorization will automatically expire one year from date of signature or until _____, 20_____. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on the actions they took before they received the revocation.

Any refusal to sign this form will not affect my ability to obtain treatment, payment or my eligibility for benefits. I may request to inspect or copy the health information to be used or disclosed. This release is not valid if it does not contain the patient signature.

Patient Information:

Name _____ Date of Birth _____ Medical Record Number _____

Previous Name _____

Street Address _____ City _____ State _____ Zip Code _____

Daytime Phone Number _____

Release Information From:

Name _____

Street Address/P.O. Box _____

City, State, Zip Code _____

Phone Number _____ Fax Number _____

Send Information To:

Upcoming appt. date _____

Name _____

Street Address/P.O. Box _____

City, State, Zip Code _____

Phone Number _____ Fax Number _____

I understand this does not include any correspondence/records generated from non-McFarland facilities. Those will need to be obtained from that particular facility.

Medical Information to be released:

___ Office Notes (this will be limited to 2 years of information including lab and x-ray, unless otherwise specified)

___ Lab ___ Pathology ___ X-Ray Reports ___ X-Ray films, images ___ OB Flow Sheet

___ Physical Therapy ___ Immunizations ___ Cardiovascular images ___ EKG

___ Billing Information ___ Other-Specify _____

For date(s) of treatment or condition _____

The information disclosed may include matters regarding mental health/depression, alcohol or drug abuse, infectious diseases, including HIV and genetic testing information. Refusal to consent to release information will result in such confidential records not being released.

If you do not wish such information to be released, state information to be excluded: _____

I am requesting this information to be released for the following purpose:

___ Medical Treatment ___ Transfer of Care ___ Worker's Compensation ___ Insurance ___ Disability

___ At My Request ___ Legal ___ Moving ___ Other

A copy of this signed form will be provided to the patient.

Signature of Patient or Legal Representative _____ **Date** _____

Relationship, if not patient_____. Legal documentation is required supporting his/her authority to act on a patient's behalf.

Photo identification will be requested for all hand carry release of information requests.
Facsimile reproductions of the signature are acceptable.
There is a service fee for medical record transfer requests.

For Clinic Use

Reviewed and approved by

Dr. _____ Processed by_____

Date Approved_____ Date Completed _____