FIRSTCARE MEDICAL CENTERS, LLC.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Note: This request is not valid until all requested information is provided.

Medical Record Number: _____

AUTHORIZATION TO DISCLOSE THE HEALTH INFORMATION OF:

- **Myself:** _____
- **My Child, whose name is:** _____
- **Parent or Legal Guardian Name:** _____
- **My Legal Ward, whose name is:** _____
- **Date of Birth:** _____ **Social Security No:** _____
- **Phone No:** _____ **Fax No:** _____
- **Address:** _____

THIS AUTHORIZATION IS TO DISCLOSE INFORMATION TO:

- **Name:** _____
- **Address:** _____

  _____
- **Received by:** _____ Mail Or _____ Pick up **Phone No:** _____
- **The purpose of this Disclosure is:** _____ My Personal Use _____ Other

  (Please specify) _____

I HEREBY REQUEST: _____ To Review _____ To Copy

For the date range of _____/_____/_____ to _____/_____/_____ **or**

Or pertaining to: _____

PLEASE SEND THE INFORMATION AS INDICATED BELOW:

☐ Diagnosis / Procedure ☐ Discharge Summary ☐ Assessment Evaluation

☐ Most Recent History ☐ X-Ray films / images ☐ X-Ray Report

☐ Emergency Department Visits ☐ Care Plan ☐ Progress Notes

☐ Other: _____

Term: I understand this authorization is specifically for information created from services provided before my date of signature. Information related to services provided after my date of signature will require an updated authorization. This authorization will expire (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information services department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquire immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Signature of Patient, Parent or Legal Representative	**Date**

If signed by legal Representative, Relationship to Patient:

To be completed by FIRSTCARE MEDICAL CENTERS, LLC.:

Date Received ____/__ _/____ **Date Completed** ____/____/____ **Mail Sent** ____/____/____

Completed by: _____ **Date**____/____/_____