Family Medical Center of Hastings

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Authorization to Disclose and Obtain Information

PATIENT _____
Last First Middle Maiden

Date of Birth Address City State Zip

REQUEST I hereby authorize Family Medical Center of Hastings to:

☐ **DISCLOSE TO:** ☐ **OBTAIN FROM:**

Organization or Individual Phone Number

Street Address City, State, Zip

Fax Number

PURPOSE OF DISCLOSURE

☐ Appointment _____ Appointment Date

☐ Consultation with another physician; will continue as a patient at Family Medical Center of Hastings

☐ Continuation of care elsewhere
☐ Personal Use
☐ Other _____

MEDICAL RECORDS I hereby authorize the above-named to disclose or obtain my medical records for the following reason:

☐ All medical records for the last _____ year(s) of treatment received

Specific description of information to be disclosed:

	Date(s)		Date(s)
☐ Chart/Clinic Notes		☐ History and Physical	
☐ X-ray/Imaging Report		☐ Complete Record	
☐ Laboratory Report		☐ Immunization Records	
☐ EKG		☐ Other	

PRIVACY Certain types of medical records will be disclosed only with your approval. Your health record may include information relating to sexually transmitted disease, acquired 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. Please indicate if any of the following medical information SHOULD NOT be disclosed.

☐ Mental health information ☐ Alcohol abuse ☐ Immunodeficiency virus infection (HIV)
☐ Drug abuse ☐ Test for HIV ☐ Acquired Immunodeficiency syndrome (AIDS)
☐ Sexually Transmitted Disease

AUTHORIZATION 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 Family Medical Center of Hastings. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire six (6) months after the date signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or receive a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer of Family Medical Center of Hastings.

A photocopy of this authorization shall be considered as valid as the original.

Signed: _____ Date: _____
Patient/Personal Representative

_____ _____
Relationship (if not patient) Witness