

**MEDICAL RELEASE AUTHORIZATION**

**FANNO CREEK CLINIC, LLC**

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*Please print*

I (patient's name): \_\_\_\_\_, DOB: \_\_\_\_\_,  
authorize the disclosure of my health information as identified below. **FROM** [provider's name/ address]:

\_\_\_\_\_  
**TO** [recipient's name/address]: \_\_\_\_\_

for the following purpose(s) [please initial]: Change of provider \_\_\_\_\_, Continuity of care \_\_\_\_\_  
"At the request of the patient" \_\_\_\_\_, or Other (describe and initial): \_\_\_\_\_.

By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and records:

- \_\_\_\_\_ Entire medical record (all information)
- \_\_\_\_\_ Billing record
- \_\_\_\_\_ Medical records developed from \_\_\_\_\_ to \_\_\_\_\_ [start date/end date]
- \_\_\_\_\_ \*\*Other [specify]: \_\_\_\_\_.

\*\*If the information to be used or disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information may apply. I agree the following categories must be initialed to be included in this authorization to release information.

- \_\_\_\_\_ \*\*HIV/AIDS related health information/records
- \_\_\_\_\_ \*\*Mental health information/records
- \_\_\_\_\_ \*\*Genetic testing information/records
- \_\_\_\_\_ \*\*Drug/alcohol diagnosis, treatment and/or referral information. Federal law prohibits the redisclosure of this health information. Federal law requires that a description of the kind of information and how much be included in this request: \_\_\_\_\_.

\_\_\_\_\_ \*\*\*Psychotherapy notes [If authorization is for the disclosure of psychotherapy notes, it cannot be combined with any other authorization.]

**\*\*\*REQUIRED:** Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. **Unless revoked earlier, this authorization will terminate on [date or event]:** \*\*\* \_\_\_\_\_ \*\*\*.

I understand I may inspect or copy any information disclosed under this authorization unless otherwise restricted by law. I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the provider described above may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I understand that the person(s) I am authorizing to use or disclose my information may receive compensation for doing so.

\_\_\_\_\_  
Signature of Individual or legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)