Family Health Center

Health Information Department
PO Box 556
Vincennes, Indiana 47591

Authorization to Disclose Health Information from the Family Health Center (FHC)

First Name:	Middle Name:	Last Name:	
Name at Time of Treatment (If different than above):			
Date of Birth (MM/DD/YYY):	Phone:	Email (optional):	
Street Address:	City:	State:	Zip:

Where do you want the information sent? (Fill in the boxes below):

Recipient Name:	Recipient Phone/Fax:
Recipient Mailing Address:	Recipient Email (if applicable):

Purpose of Disclosure:

☐ Self ☐ Continuation of Care ☐ Other _____

How would you like your records to be delivered?

☐ Paper ☐ CD/Flash Drive ☐ Verbal
☐ Mail ☐ In-Person Pickup ☐ Fax ☐ Email

What records do you want? (Check the appropriate boxes below):

Date(s) of Services: _____/ _____/ _____ through _____/ _____/ _____

☐ Check box for all Dates of Service

☐ Office Visits
☐ Billing/Payment Records
☐ Scheduling/Appointment Information
☐ Medical Information (including symptoms, diagnosis, medications & treatment plans
☐ Behavioral Health Information (including symptoms, diagnosis, medications & treatment plans)
☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____
☐ Other (Immunization Records, Medication Lists) Please specify: _____

General Health Information

FHC is authorized to release my general health information, which includes provider office medical records, billing records, and images. This authorization does **NOT** include genetic, mental health, sexually transmitted disease (STD), or substance use disorder care treatment records, the release of which may only be authorized through completion of the "Specialty Records" section below.

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Specialty Health Information

Federal and State laws protect the following information. Please indicate if you would like this information to be released as part of this authorization: (Include dates if applicable)

Alcohol, Drug, or Substance Abuse Records	☐ Yes ☐ No
HIV Testing and Results	☐ Yes ☐ No
Mental Health Records	☐ Yes ☐ No
Psychotherapy Records	☐ Yes ☐ No
Genetic Records	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No

_____ Initial here if you would like to limit this Authorization to information related to specific dates of service and NOT the entire medical record related to the specialized area(s) checked above.

Indicate authorized dates of service here: _____

Patient Understandings

- This authorization will expire in 180 days unless I specify a different expiration date below:
  ☐ One Year ☐ Other _____
- I understand that I have the right to revoke this authorization at any time. I understand that I should tell all agencies and people listed on this form if I withdraw my consent. The revocation will not apply to any information that has already been released in response to this authorization.
- I understand that my treatment, payment, enrollment, or eligibility benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by law.
- I understand if FHC has received and used records received from other entities for treatment, these records may be released pursuant to this authorization.
- I understand that FHC cannot prevent redisclosure of my records by the receiving party under this authorization, and that information may no longer be protected under federal and state law after its release.
- I authorize the Family Health Center to release information on my substance abuse treatment for any insurance related items, billing, prior authorization, records for payment, etc.
- I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

A copy of this Authorization will be included with any printed/electronic production of your health records pursuant to the Authorization.

Note: Only the patient may authorize the release of records regarding care and treatment for sexually transmitted diseases, other communicable diseases, or substance abuse. No such records may be released without the patient's signature.

For mental health records, this Authorization should be signed by the patient and, as applicable, the patient's parent, guardian, or other court-appointed representative. If the patient is incapable of giving or withholding consent, the patient's guardian, a court-appointed representative of the patient, a person possessing health care power of attorney, or the patient's health care representative may authorize the release of records

Please print your name and sign below:

Name of the Patient or Personal Representative (please print)	Relationship (please print)
Signature of Patient or Personal Representative	Date/Time
Signature of Witness to Signing	Date/Time

If the record(s) released contain drug and/or alcohol information, then this information has been disclosed to you from records protected by Federal Confidentiality Rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.