whole family health center

Authorization to Obtain Medical Information

Patient Information:

Patient Name: _____

LAST FIRST MI MAIDEN OR OTHER

DATE OF BIRTH		MEDICAL RECORD #
ADDRESS	CITY/STATE	ZIP CODE

INFORMATION RELEASED **FROM:**	INFORMATION RELEASED **TO:**
NAME	NAME
ADDRESS	ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
FAX NUMBER	FAX NUMBER
TELEPHONE NUMBER:	TELEPHONE NUMBER:

Information to be Obtained or Inspected: (Check all requested categories)

____Entire Chart/Record
____Immunization Record
____Discharge Summary
____History & Physical
____Operative Reports
____Pap Smear Reports
____Pathology Reports
____Hepatitis Serology
____All CD4 & Viral Load Record
____Record of Treatment for STI
____Health Maintenance Record
____X-ray & Other Radiology Reports
____Laboratory Reports
____Antiretroviral Treatment History
____Treatment for Hepatitis B or C
____Initial Office Visit Notes
____Last 2 Office Visits Notes
____Problem List
____Worker's Compensation
____All Genotypes/Phenotypes
____Proof of Neg PPD or TB Treatment
____Assessment/Bio-Psychosocial Reports
____Billing & Patient Account Records
____Positive Western Blot
____Copies of Reports Originating from Other Provider
____Mental Health/Alcohol or Drug Abuse Treatment/Attendance
____Social Services Reports and/or Evaluations

____Other: _____

Reason for Disclosure: **Continuation of Medical or Behavioral Health Care**

This authorization will remain in effect for one (1) year and will be effective for medical records generated up to the expiration date of the consent.
I understand that:

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization.
2. These records may contain information including psychological, psychiatric, substance abuse/alcohol abuse HIV/AIDS results, testing and/or progress notes.

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

_____ _____

Signature of Patient or Patient's Legal Representative Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain):_____