FRANKLIN COUNTY FCMC MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____

Medical Record Number: _____

☐ Pick Up Copies ☐ Fax Copies ☐ Mail Copies ☐ View Record

ID Confirmed By: _____

AUTHORIZATION

I hereby authorize Franklin County Medical Center and Willow Valley Medical Clinic to disclose health information as specified to:

Organization/person to receive health information: _____

Address: _____

City: _____ State: _____ Zipcode: _____

INFORMATION TO BE DISCLOSED

Please select one or both options: ☐ Franklin County Medical Center ☐ Willow Valley Medical Clinic

☐ Discharge Summary	☐ Consultation Reports	☐ Lab	☐ Radiology Reports
☐ History & Physical Exam	☐ Operative Reports	☐ Pathology	☐ Entire Record
☐ Other Specify: _____			

Date(s) of Hospitalization/Care: _____ _____ _____ _____

CHECK IF APPLICABLE

I understand that the disclosure may include information relation to:

☐ AIDS or HIV ☐ Psychiatric or Mental Health Information ☐ Drug/Alcohol Abuse Information

I understand that the information to be released may include material that is protected by Federal Law (45CFR Part 164) and that the information may be subject to redisclosure by the recipient and no longer be protected by the federal regulations. I understand that this authorization may be revoked in writing at any time by notifying the privacy officer, except that revoking the authorization won't apply to information already released in response to this authorization. I understand that FCMC will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. Unless otherwise revoked, this authorization will expire in 90 days from the date below or in the event of the following condition:

Franklin County Medical Center, its employees, officers, and physicians are hereby released from any legal responsibility or liability of disclosure of the above information to the extent indicated and authorized by me on this form and as outlined in the Notice of Privacy. My signature below authorized release of all information specified in this authorization. Any questions that I have regarding disclosure may be directed to the privacy health officer at 208.852.0137.

_____

Patient Signature Date

_____

Signature of Legal Representative & Relationship to Patient/Authority to Act Date

_____

Witness Signature Date