FRANKLIN COUNTY
FCMC
MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: __________

Address: ______________________

City: __________ State: __________ Zipcode: __________

Phone Number: ______________________

HOW WOULD YOU LIKE TO RECEIVE THESE RECORDS?

☐ Pick Up Copies Phone Number: __________

☐ Fax Copies Fax Number: __________

☐ Mail Copies Address: __________

☐ Email Copies Email: __________

WHO CAN HAVE THESE RECORDS? (REQUIRED)

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

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

☐ Discharge Summary ☐ Consultation Reports ☐ Lab ☐ Radiology Reports

☐ History & Physical Exam ☐ Operative Reports ☐ Pathology ☐ Entire Record

☐ Other Specify: ______________________

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

CONSENT FOR DISCLOSURE OF HEALTH 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: ______________________ Date: __________

Relationship to Patient: ______________________

FOR OFFICE USE ONLY

☐ Records Requested

☐ Records Released

Witness Signature: ______________________ Date: __________