Family Medical Center of Hart County
P. O. Box 579 Munfordville, KY 42765
Phone – (270) 524-7231 Fax – (270) 524-7415

HIPAA Compliant Authorization To Request Information

The purpose of this requested disclosure is: **Continuity of Care**

Patient's name: ____________________________________DOB__________________SSN:________________

To: 1. ____
Person/Provider/Agency name/Address Phone Fax
2. ____
Person/Provider/Agency name/Address Phone Fax
3. ____
Person/Provider/Agency name/Address Phone Fax

I request and authorize the release of health care information from the person/provider/agency indicated above to **Family Medical Center of Hart County**.

This request and authorization applies to the checked items selected below. Please send the past ____ year(s).

___ History & Physical

___ List of Medical Diagnosis

___ Past Surgeries

___ List of Known Allergies

___ Any Diagnostic Testing (CT, MRI, U/S, UGI, EEG, VCUG)

___ **Last Two** Visit Notes Only

___ Immunization Record

___ List of Current Medications

___ EKG/Cardiac Testing

___ Progress Notes from Specialists

___ **Last Set** of Visit Notes & Labs

□ **Patient NOT changing Primary Care Provider**

___ **Other (**specify- include dates) ____

* IMPORTANT*

SEPARATE ACKNOWLEDGEMENT REQUIRED for RELEASE OF SENSITIVE INFORMATION**

Medical information related to alcohol abuse, drug abuse, HIV/AIDS, testing for HIV/AIDS, venereal disease or mental/emotional disorders, is ***protected by Federal and/or State Law*****.** This type of medical information requires a separate acknowledgment from the patient/personal representative that this information is to be released and is included in the authorization being made.

Specify the nature of the information to be released:____

Patient/Personal Representative's initials_________________________

- I understand that I have the right to cancel this authorization at any time by written notification. Said written notification must include the name or other specific identification of the person(s) that are to no longer receive information, signed and dated by the patient or authorized representative. In lieu of written notification the FMC Revocation of Authorization for Use and Disclosure of Health Care Information form may be completed. I also understand that my cancellation is not effective for any information that may have been released based on this authorization prior to my cancellation of this authorization.

- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires: _____30 days _________ 60 days ________ 90 days_____365 days or state a specific date or event below

____.

Refusal to sign this authorization will not result in the provider conditioning the provision of healthcare. **(Initials)** _____________.
This authorization remains on file and I may receive a copy of this form once signed. **(Initials)** ______________.

____ ____________________________________
Signature of patient or patient's authorized representative Date signed Witness Date signed

____ ______________________________
Name of patient or Personal Representative Relationship

02/ 16/ 2004 bgc, 05/27/2011 bgc, 09/19/11 che, 03/11/13 che, 03/13/14 che, 07/08/14 che, 03/25/15 che

Additional Elements Only if: The Practice/Provider is requesting the Authorization for His/Her Own Use and Disclosure of the Individuals Health Information.

The purpose of this requested disclosure is: ______________________________________

____

____

I understand that I may inspect or copy the Protected Health Information to be used or disclosed and will receive a copy of this form once signed. ______________
Patient initials

I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of Healthcare. ______________
Patient initials

This disclosure will result in direct or indirect payment to the physician. ____ Yes ____ No

____
Signature of patient or patient's authorized representative Date signed

____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)