

Request for Family Medical Center, PA to **Receive Protected**
Health Information from Someone Else

Section 1 – Description of the Protected Health Information To Be Disclosed

Please specify what copies are being requested as well as the specific time frames.

- | | | |
|---|-----------------------|-----------|
| Doctor's office notes: | last five years | all |
| Lab & X-ray reports: | last five years | all |
| Records of hospital inpatient and outpatient services: | | |
| | last five years | all |
| Records of other services: | last five years | all |
| Copies of records which you have had forwarded from other hospitals or
Physicians: | | |
| | last 5 years | all |
| Copies of administrative reports/letters: | last 5 years | all |
| Copies of everything in the chart: | last 5 years | all |
| Include copies of records pertaining to mental health, alcoholism, HIV,
developmental disabilities, drug abuse, and sexually transmitted diseases. | | |
| | last 5 years | all |

If the choices above do not allow you to adequately describe the information you want disclosed, please describe your request in writing on a separate page and attach it.

Your records will be part of Family Medical Center, PA designated record set.

Section II – Individual Authorized to Make the Disclosure

Please specify whom is authorized to disclosure the requested protected health information.

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.....
.....

Section III – Identity of Individual to Receive Disclosed Information

Please send the requested protected health information to:

Medical Records Department
Community Medical Center
200 South First Avenue
Pierz, Minnesota 56364

Section IV – Purposes for the Disclosure

----- At the request of the individual

----- Other: If you feel it is necessary to honor your wishes, you may attach a written explanation of the purposes for disclosing the information.

Section V – Expiration

----- This authorization expires in 30 days

----- This authorization expires on: ----- OR

----- This authorization expires with the following event: -----

Section VI – Required Statements

You have a right to revoke this authorization at any time as explained in the clinic’s Notice of Privacy Practices. You have the right to receive your own copy of the *Notice of Privacy Practices*.

The covered entity whom you are authorizing to disclose protected health information may not condition treatment, payment, enrollment or eligibility for benefits in the future on whether or not you sign or revoke this authorization.

You must understand that there is the potential for information disclosed pursuant to this authorization to be the subject of redisclosure by the recipient and no longer protected by the federal HIPAA regulation.

Section VII – Signature

I agree that a photocopy of this authorization may be accepted in lieu of the original.

Patient Name:

DOB:

Name of person requesting access if not the patient

Relationship to patient

Signature

Date of Signature