

**Incoming Request for Protected Health Information (PHI)**  
AUTHORIZES THE FACILITY/PERSON YOU LIST BELOW TO RELEASE INFORMATION TO OUR OFFICE

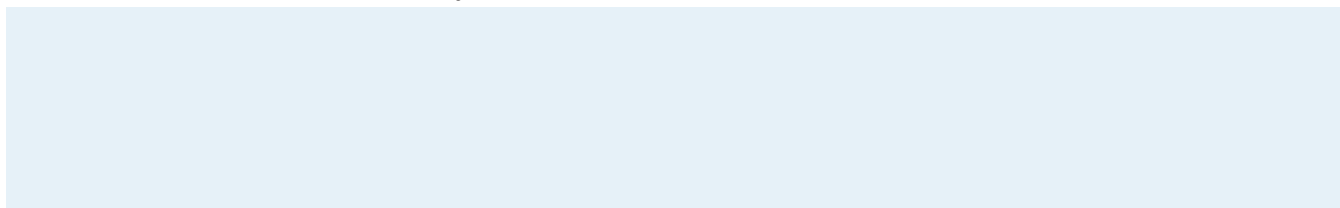
Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

**I. I authorize:** Facility/clinic: \_\_\_\_\_  
Provider/person: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

**To disclose health care information to:**

**Family Care Network**



**You may use or disclose the following health care information (check all that apply):**

- All health care information in my medical record (*see next section to release protected information*)
- Health care information in my medical record relating only to the following treatment or condition:  
\_\_\_\_\_
- Health care information in my medical record only for the date(s) of: \_\_\_\_\_
- Laboratory/X-Rays/Imaging: \_\_\_\_\_
- Billing/Payment: \_\_\_\_\_

**You may use or disclose information regarding testing, diagnosis and treatment for (check all that apply):**

- HIV (AIDS virus)  Sexually transmitted diseases
- Mental health or illness  Drug and/or alcohol use
- Reproductive health care – **only for minors under 18 years of age**

**Minors** – a minor patient’s signature is required in order to disclose information related to reproductive care (*at any age*), sexually transmitted diseases (*age 14 and older*), HIV/AIDS (*age 14 and older*), drug and/or alcohol abuse (*age 13 and older*), and mental health or illness (*age 13 and older*).

*-Continued on back-*

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

- At my request
- Transfer of care
- Other (specify): \_\_\_\_\_
- For marketing purposes

**This authorization ends:**

- On a specific date: \_\_\_\_\_
- When the following event occurs: \_\_\_\_\_
- 90 days from the date signed
- When I cancel this authorization

**II. My Rights**

- A. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
  - to receive research-related treatment in connection with research studies **or**
  - to receive health care when the purpose is to create health care information for a third party.
- B. I may cancel this authorization in writing at any time. If I do, it will not affect any actions taken by Family Care Network in reliance on this authorization before it receives my written cancellation. I may not be able to cancel this authorization if its purpose was to obtain insurance. To cancel this authorization:
  - complete the box below
  - write a letter to Family Care Network

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Patient or legally authorized individual signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

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Printed name (if signed on behalf of the patient) \_\_\_\_\_ Relationship (*parent, legal guardian, personal representative*) \_\_\_\_\_

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Minor patient's signature, if applicable \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

<input type="checkbox"/> <b>CANCEL THIS AUTHORIZATION</b>
Patient signature: _____ Date: _____