Family Care Network
We Take Care

Outgoing Request for Protected Health Information (PHI)

AUTHORIZES FCN TO RELEASE INFORMATION TO THE FACILITY/PERSON YOU LIST BELOW

Patient name: _____ Date of birth: _____

Previous name: _____

I. I authorize: Family Care Network: *(Including all clinics, offices and ancillary services)*
709 W. Orchard Drive, Suite 4
Bellingham, WA 98225

To disclose health care information to:

Facility/clinic: _____

Provider/person: _____

Address: _____

Phone: _____

Fax: _____

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

III. Protection after Disclosure

Information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (*parent, legal guardian, etc.*)

_____

Minor patient's signature, if applicable Date Time

☐ **CANCEL THIS AUTHORIZATION**

Patient signature: _____Date: _____