

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check all that Apply:**

 **Records to be sent to:**  **Records to be received from:**

Name/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Disclosure:** (Check all that apply)

* Coordination of Care
* Transfer of Care
* Personal Records
* Legal/Court Hearing
* School
* Disability
* Insurance/Billing

**Information to be Released:** (Check all that apply)

* Clinical Progress Notes
* Medication Records
* Immunization Records
* Laboratory Results
* Specialist Records
* Hospital Records
* X-Rays/Cat Scan/Ultrasound/MRI
* All Records

**Format to be Released:** (Check all that apply)

* Paper/Hard Copy
* Verbal
* Electronic/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEES\*:** Fees are authorized annually by state law. Fees **MUST** be paid before records can be released. Record fees will be billed as follows;

**Clients and Service Providers** - Paper Copies: 76¢ per page, plus $22.88 Service Fee

 Electronic Copies: Cost of Labor $40/Hr

**Attorneys/Insurance Companies/Other** - 76¢ per page, plus $22.88 Service Fee

\*Cash, Check or Credit

**Legal Authority:** Please review the information carefully. If information is missing the request may not be processed.

If the client lacks capacity to sign, a legally authorized person may sign and date the form.

Please indicate your legal authority and include documentation of your relationship:

 Power of Attorney/Health Care Proxy Legal Guardian or Counselor Other:\_\_\_\_\_\_\_\_\_\_\_

Foster Medical Care, employees, volunteers, and agents have a duty to maintain confidentiality of any protected health information disclosed to them pursuant to the authorization. The client or authorized person may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it, by providing written notice to Foster Medical Care. Unless otherwise noted below, this authorization will expire in 12 months from the date of consent. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and/or state confidentiality laws, including HIPPA. Foster Medical Care may not condition treatment, payment, enrollment, or eligibility for services on whether the client signs this authorization. The client has a right to a signed copy of this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Client or Authorized Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_