FreeState PRIMARY CARE

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME | DOB | SSN

ADDRESS | PHONE

I authorize Free State Primary Care, LLC, to:

☐ Release my health information to the below facility/clinician ☐ Receive my health information from the below facility/clinician

NAME OF PROVIDER/FACILITY | EMAIL

ADDRESS | PHONE | FAX

TYPE OF DISCLOSURE

☐ Verbal/Written/Electronic ☐ Copies of Record ☐ Letter

PURPOSE OF DISCLOSURE

☐ Ongoing treatment ☐ Academic ☐ Support ☐ Other

DESCRIPTION OF INFORMATION TO BE DISCLOSED

☐ Assessment ☐ Diagnosis ☐ Psychiatric Evaluation ☐ Medication Management Info ☐ Discharge ☐ Other

By initialing below, you are authorizing the following information to be released:

____ **All counseling/mental health information** (Subject to MD's Confidentiality of Medical Records Act, codified at Health-General4-301 et seq.) Additionally, all information regarding alcohol and/or Drug Abuse (42. C>F.R. and 2.35) or HIV/AIDS results (Health and Safety Codes 120980(g)) will be released **unless restricted in Comments below.**

____ **All medication management services information medical information.** (This may include but is not limited to drug/alcohol and mental health information documented by the medical provider.)

____ I understand that this information may be transmitted via written word, facsimile, or over the phone.

____ I understand authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request.

____ I understand that if I do not revoke this consent at any time, the consent will expire one year from the date of signing below.

____ **Comments regarding the release of information** (i.e. specific information you do not wish to be released):

REDISCLOSURE

I understand that there is the potential that the protected health information that is disclosed is pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

PATIENT NAME | DOB

SIGNATURE PATIENT/GUARDIAN

DATE