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 _____

AUTHORIZATION

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 _____

AUTHORIZATION

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

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

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:** _____