FRANCISCAN CARE SERVICES
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____ D.O.B. _____

ADDRESS _____ PHONE # _____

I hereby authorize _____ to disclose my health information as follows:

DISCLOSE TO: _____
Recipient Name Address Phone Number

PURPOSE(S) OF DISCLOSURE: _____

☐ Check this box if disclosure is at the request of the individual.

INFORMATION TO BE DISCLOSED

☐ History and physical examination	☐ Emergency room record
☐ Progress notes	☐ Discharge report
☐ Lab reports	☐ Financial record
☐ X-ray reports	☐ Complete record
☐ Consultation report	☐

I specifically authorize the release of information relating to:

☐ HIV/AIDS related information (including test results)
☐ Mental Health
☐ Genetic Testing Results

Dates of service or time period of records to be disclosed: _____
(State time period or "all")

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment.

2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.

3. This authorization is effective for 12 months after the date it was signed unless otherwise specified. I understand that I may revoke this authorization at any time by giving written notice to HIM. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative Date Time

_____ _____
Relationship to patient if signed by personal representative Witness