FAMILY FIRST
WOMEN & CHILDREN'S HEALTHCARE
MEDICAL AESTHETICS

Authorization for Release of Medical Records

Patient Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Phone Number: _____

I hereby authorize that the protected health information regarding the above-named person be forwarded FROM:

Name: _____

Address: _____

City/State/Zip: _____ Phone Number: _____

TO:

Name: _____

Address: _____

City/State/Zip: _____ Phone Number: _____

Purpose of authorization:

- ☐ Transfer of care
- ☐ Coordination of Care
- ☐ Other: _____

**Please note that if you wish to include ALL records, you must check ALL of the boxes below:

- ☐ Entire medical record, ***excluding*** records for the treatment of mental health, alcoholism, drug abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS).
- ☐ Mental health treatment records
- ☐ Alcoholism treatment records
- ☐ Drug abuse treatment records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) records
- ☐ Other: _____

From the time period: _____ to _____.

I understand that I have the right to inspect a copy of the information I have authorized to be disclosed. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that any information used or disclosed as a result of my signing this authorization may no longer be protected by the privacy laws and may be subject to re-disclosure by the person or entity receiving it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that I may revoke this authorization at any time by giving written notice to Family First Physicians (FFP) of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where FFP has already relied on it or used or disclosed my health information. Written revocation must be sent in writing FFP. Absent written revocation, this Authorization for Release of Medical Records information will terminate one year from the date indicated below.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Legal Guardian Date