Authorization for Release of Protected Health Information

- Medical records are to include any and all Federal and State protected information without limitation to include diagnosis, treatment and/or examination related to mental health related care, drug and /or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.

- By signing this release, you understand that this authorization will remain in effect for 180 days or until revoked in writing (whichever transpires first). FCMG is authorized to use outside vendors for the purpose of copying and providing information requested.

- I understand the state law prohibits the re-disclosure of information disclosed to the person/entities listed above without my further authorization, but that FCMG cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.

- I understand I have the right to inspect and obtain a copy of any information disclosed.

- I hereby release FCMG and its employees from any and all liability that may arise from the release of information as I have directed.

- I understand that if I have requested duplication of records within a one-year time period (of the same or similar records) I may be charged a fee of up to $1.00 per page for every page copied. This fee may be waived for copies provided to a healthcare provider, insurance company or other specific organizations for treatment, billing or operation purposes.

Signature of Patient: _____ Date: _____

*A photo ID must be provided for proof of identity or release must be notarized. ID checked by: _____

Signature of Empowered Representative: _____ Date: _____

*Must provide POA or supporting documentation for personal representative or healthcare surrogate

Relationship to patient: _____

Witness: _____ Date: _____

Staff Use Only:

ID checked? ☐ Yes ☐ No Request processed by (initials): _____ Date: _____