***FAMILY CARE OF CHILHOWIE***

***403 CHILHOWIE ST. P.O. BOX 346***

***CHILHOWIE, VIRGINIA 24319***

***P: (276) 646-3241 F: (276) 646-2592***

***AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION***

***FORM EFFECTIVE DATE: APRIL 14, 2003***

I hereby authorize use or disclosure of the named individual’s health information as described.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are we currently seeing a family member? If so, who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release information from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information is to be disclosed:

\_\_\_\_\_Complete health record ( **LAST 3 YEARS)** \_\_\_\_\_Consultations

\_\_\_\_\_Physician Notes \_\_\_\_\_X-ray reports

\_\_\_\_\_Discharge Summaries \_\_\_\_\_Laboratory Reports

\_\_\_\_\_History & Physical Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you in advance…only fax up to 20 pages, otherwise mail….**

**RE-DISCLOSURE:** I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR REDISCLOSURE AND THAT THE INFORMATION THEN MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

**RIGHT TO REVOKE:** I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT MY REVOCATION MUST BE IN WRITING. I UNDERSTAND THAT REVOCATION WILL NOT APPLY TO INFORMATION ALREADY RELEASED BASED ON THIS AUTHORIZED.

**CONSENT WILL EXPIRE IN SIX MONTHS, UNLESS OTHERWISE REVOKED.**

**THIS FACILITY, IT’S EMPLOYEES AND OFFICERS ARE RELEASED FROM LEGAL RESPONSIBILITY OR LIABILITY FOR THE RELEASE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHROIZED HEREIN.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT OR LEGAL REPRESENTATIVE**

**If signed by Legal Representative, Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***FAMILY CARE OF CHILHOWIE, P.C.***

***SPECIAL CONDITION RELEASE***

This special form is an authorization to release confidential information from your medical records. Our standard consent form and/or authorization to use or disclose protected health information does no authorize the release of the following without your signing a special condition release.

* **AIDS (Acquired Immune Deficiency Syndrome or HIV (Human Immune Deficiency Virus) Infection**
* **SEXUALLY TRANSMITTED DISEASES**
* **SUBSTANCE ABUSE (ALCOHOL AND/OR DRUGS)**
* **PHYSICAL ABUSE**
* **PSYCHIATRIC/BEHAVORIAL OR MENTAL HEALTH**

This signed release authorizes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release PHI on specific conditions to third party recipient.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ may decline to provide treatment to me.

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**AUTHORIZATION FOR RELEASE OF**

**CONFIDENTIAL HEALTH CARE INFORMATION**

**PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_**

**MAILING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_**

This authorizes  **Family Care of Chilhowie**  to request and receive from the **Virginia Department of Health Professions** any and all records held by the Department relating to **Schedule II-IV controlled substances** dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, unless revoked in writing, this consent does not expire.

Patient signature Date

Guardian Signature Date

NOTE: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.

NOTE: If you are over the ager of eighteen (18), you may request your own information from the prescription monitoring program. The form may be found on the program website: <http://www.dhp.virginia.gov> click on Prescription Monitoring Program under Practitioner Services.

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