Fireweed Health Care, Inc.

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

I authorize my records to be released **FROM:**
Name_____
Address_____
Phone_____ Fax_____
Reason for disclosure: [ ] At the request of the individual [ ] Continuity of Care [ ] Other, please specify: _____

I authorize my medical records to be released **TO:**
Name_____
Address_____
Phone_____ Fax_____

I authorize the release of the following portions of my medical records: (please **initial** each authorized category)
_____ Mental Health _____ Substance Abuse _____ Imaging Reports _____ Office Notes
_____ Labs _____ Complete copy of file Other_____

Records to be released from the following time period: _____ through _____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies. I hereby release Fireweed Health Care, from any and all liability which may arise as a result of my authorized release of records. Should my case require review by a governing agency or another medical professional actively involved in my care, it is with my consent that a copy of these records will be submitted to the agency or medical professional for this review. This information has been disclosed to you from records protected by Federal confidentiality rules. **For all records requests involving protected records (42 CFR part 2):** The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Patient (or legal representative in lieu of the patient) _____

Relationship to Patient:_____ Date:_____

Witness:_____ Date:_____