

**FAMILY MEDICAL CENTER OF HART COUNTY  
P. O. BOX 579, MUNFORDVILLE, KY 42765  
HIPAA COMPLIANT AUTHORIZATION TO REQUEST INFORMATION**

The purpose of this requested disclosure is: **CONTINUITY OF CARE**

Patient's name: \_\_\_\_\_ DOB \_\_\_\_\_ SSN: \_\_\_\_\_

- To: 1. \_\_\_\_\_  
(Person/Provider/Agency name/Address)
2. \_\_\_\_\_  
(Person/Provider/Agency name/Address)
3. \_\_\_\_\_  
(Person/Provider/Agency name/Address)
4. \_\_\_\_\_  
(Person/Provider/Agency name/Address)
5. \_\_\_\_\_  
(Person/Provider/Agency name/Address)

I request and authorize the release of health care information from the person/provider/agency indicated above to  
**Family Medical Center of Hart County**

**This request and authorization applies to:**

- \_\_\_\_\_ **Current Problems List; Medication List; Immunization Record; Last Labs Drawn; Any Radiology from past 5 yrs.**
- \_\_\_\_\_ **Specific health care information** relating to a specific treatment, condition or date(s) of service (state the specific treatment, condition, or date (s) of service) \_\_\_\_\_
- \_\_\_\_\_ **Other** (specify- include dates) \_\_\_\_\_

**\* IMPORTANT\***

<b>SEPARATE ACKNOWLEDGEMENT REQUIRED for RELEASE OF SENSITIVE INFORMATION**</b>
<i>Medical information related to alcohol abuse, drug abuse, HIV/AIDS, testing for HIV/AIDS, venereal disease or mental/emotional disorders, is <b>protected by Federal and/or State Law</b>. This type of medical information requires a separate acknowledgment from the patient/personal representative that this information is to be released and is included in the authorization being made.</i>
<b>Specify the nature of the information to be released:</b> _____
<b>Patient/Personal Representative's initials</b> _____

- I understand that I have the right to cancel this authorization at any time by written notification. Said written notification must include the name or other specific identification of the person(s) that are to no longer receive information, signed and dated by the patient or authorized representative. In lieu of written notification the FMC Revocation of Authorization for Use and Disclosure of Health Care Information form may be completed. I also understand that my cancellation is not effective for any information that may have been released based on this authorization prior to my cancellation of this authorization.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

**This authorization expires:** \_\_\_\_\_ **30 days** \_\_\_\_\_ **60 days** \_\_\_\_\_ **90 days** \_\_\_\_\_ **365 days** or state a specific date or event below

\_\_\_\_\_.

Refusal to sign this authorization will not result in the provider conditioning the provision of healthcare. **(Initials)** \_\_\_\_\_.

This authorization remains on file and I may receive a copy of this form once signed. **(Initials)** \_\_\_\_\_.

\_\_\_\_\_  
Signature of patient or patient's authorized representative- Date signed

\_\_\_\_\_  
Witness Date signed

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Name of patient or Personal Representative \_\_\_\_\_

Relationship \_\_\_\_\_

**Additional Elements Only if: The Practice/Provider is requesting the Authorization for His/Her Own Use and Disclosure of the Individuals Health Information.**

The purpose of this requested disclosure is: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I may inspect or copy the Protected Health Information to be used or disclosed and will receive a copy of this form once signed. \_\_\_\_\_  
Patient initials

I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of Healthcare. \_\_\_\_\_  
Patient initials

This disclosure will result in direct or indirect payment to the physician. \_\_\_\_\_  
Yes No

\_\_\_\_\_  
Signature of patient or patient's authorized representative      Date signed

\_\_\_\_\_  
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)