Webster Family care

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Section A : required for all authorization's for release of PHI or right to access

Patient Name: **Birth Date / /**

Patient Phone Number: **SSN:**

Doctor's Name: City/State **Phone Number**:

Fax Number:

Purpose of Disclosure: CONTINUITY OF CARE

- ⬭ All PHI
- ⬭ Medication Record
- ⬭ Imaging/Radiology
- ⬭ Hospital Record (FULL)
- ⬭ Laboratory
- ⬭ Immunization Record

I acknowledge and hereby consent to such, that the released information may contain alcohol drug abuse psychiatric and HIV/AIDS results.

I understand that:

- **I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, drug screenings).**
- **I may revoke this authorization at any time in writing, but if I do, it will not have ay effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices**
- **If the requester or receiver is not a health plan of healthcare provider, the release information may no longer be protected by federal privacy regulations and may be disclosed.**
- **I understand that I may see and obtain a copy the information described in this form, or a reasonable copy fee, if I ask for it.**
- **I will receive a copy of this form after I sign it.**

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signatures of Patient/Guardian/Patient Representative: Date:

Print Name of Patient's Representative: Relationship to Patient: