FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

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HIPAA Compliant Authorization Form

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Full Range Health Services to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 90 days from the date of signature if not otherwise requested.

I further understand that I may revoke this authorization at any time by notifying, in writing, Full Range Health Services where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

Patient Name: _____ Date of Birth: _____

Street Address: _____

Telephone Number: _____

The information will be released to (Check off the appropriate option)

___ Patient/Designee ___ Attorney ___ Other: _____

___ Health Care Entity/POA ___ Insurance Company

Individual/ Organization Name: _____

Street Address: _____

Telephone Number: _____

Purpose of the use and/or disclosure: ☐Continued Care ☐Legal ☐Insurance ☐Personal Use ☐Other:

Information to be released: Include this information if applicable:

☐Summary Abstract only (clinic notes, history/physical, procedure reports, consultations, discharge summary)

☐Complete Chart ☐Medication ☐Provider Orders (DME)

☐Billing Record ☐History/Physical ☐Progress Note(s)

☐Other:

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

_____ _____

Signature of Patient or Legal Representative (electronic signatures not acceptable) Date

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient

_____

Representative's Authority to Act for Patient
(attach supporting documentation)