Free Clinic of Pulaski County, Inc.

Providing Healthcare to the Uninsured

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, do hereby authorize and request the **Free Clinic of Pulaski County, Inc.** to release and disclose protected health information of:

Patient Name: _____

Address: _____
_____
_____

Date of Birth: _____
Social Security #: _____-_____-_____
Phone #: _____

To the following Person, Agency, or Health Care Entity:

Name: _____

Address: _____
_____
_____

Phone #: _____
Fax#: _____

Protected Health Information to be released:

○ Discharge Summary ○ Complete Record ○ Other _____	○ History & Physical ○ Radiology Reports/Films ○ Lab Reports ○ Operative Path Reports	○ Emergency/Outpatient ○ EKG/EEG/ECHO/Stress ○ _____ Treatment Dates Requested

The purpose of this disclosure is for: _____ Medical Care _____Other:_____

I understand that:

- By signing this Authorization, I am giving the Health Care Entity permission to disclose confidential health records.
- My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.
- I may withdraw (revoke) this Authorization in writing. Withdrawal of this Authorization does not affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- There is a potential that information disclosed may be re-disclosed by the recipient and no longer protected by law.
- A copy of this Authorization and a notation concerning the person or agencies to which disclosure was made shall be included with the original health records.
- This Authorization will automatically expire one year after the date signed below **OR** on _____.
- A fee may apply to copies of PHI that I receive. I may ask for a cost estimation/invoice prior to the information being copied.

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

Revised 2014