BlessedCare Center, Inc

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AUTHORIZATION FOR REALEASE OF MEDICAL RECORDS

Patient Name: _____
SS#:_____ DOB _____
Address: _____
Telephone Number: _____
I authorize _____
to release the following information:

To: _____
Address: _____
For the Purposes of: _____
(You may indicate "At the request of the individual.")

I authorize the release of the specified information from my medical record. Unless otherwise indicated, my authorization may include the release of the following, please strike through those you wish to exclude, if any:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment
- Genetic test results and/or related treatment.
- Other:

I understand that this authorization shall be in effect for one (l) year from the date signed. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office and if I do revoke this authorization it will not have any effect on actions that BlessedCare Center took before the revocation was received.

A photocopy of this authorization shall constitute a valid authorization. I understand that once my records have been released the medical office cannot retrieve them and has no control over the use of the already released copies.

I understand that my treatment or continued treatment by BlessedCare Center is in no way conditioned on whether or not I sign this authorization.

PROHIBITION ON REDISCLOSURE: The confidentiality of the information disclosed pursuant to this authorization is protected by State and Federal law. However, I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by Federal privacy regulations.

Date: _____ Signed: _____
(Patient)

If patient is unable to give consent because of physical/mental condition or age, complete the following:
Patient is: ( ) a minor_____ years of age
( ) is unable to give authorization because _____
Date: _____ Signed: _____
Underline One: Patient Guardian/ POA/ Conservator/ Executor/ Other

Personal Representative(s) must provide appropriate documentation to verify your legal authority to act on this patient's behalf.