The Free Medical Clinic: Authorization of Medical Records

Free Medical Clinic (FMC) knows that health information is personal, and we are committed to protecting the privacy of your information. As a patient of FMC, the care and treatment you receive is recorded in a healthcare record. In order to best serve your medical needs, we sometimes must share your medical record (in whole or in part) with other healthcare providers involved in your treatment, or with other entities during the normal course of business operations. We will not use or disclose your health information for any other purpose without your permission.

I,____, give my consent and authorize the FMC to release information from my records to other health care providers for purposes of continuity of care.
In addition, I give FMC my consent and authorization to obtain my medical, dental, and/or behavioral/mental health records from other providers for purposes of continuity of care.
This authorization may be revoked by me at any time, except to the extent that action has already been taken.
I have the right to refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, unless allowed by law.

This consent continues as along as you are a patient of FMC or if you do not have an appointment with FMC in a 12-month time period.

Signature of Patient:______________________________________ **Date**

Patient Date of Birth:__________________________ **Social Security Number:**

(or) Signature of Parent, Guardian, or Legal Representative:

Please list your contact numbers, and check which one is your preferred method to reach you.

Home:_________________________________ ***Cell:*** _________________________

Work:__________________________________ ***Other:*** _______________________

I hereby authorize FMC staff and volunteers to leave messages regarding my health care in the following manner when I am not available:
(Please check the appropriate boxes to indicate your selection.)
__________ Only leave information with me, not with anyone else (if you check here, no other choices should be marked)
__________ May leave appointment reminders on my voicemail and/or on my answering machine
__________ May leave lab reports on my voicemail and/or on my answering machine
__________ May leave general questions/information on my voicemail and/or on my answering machine

And I hereby authorize FMC staff and volunteers to speak with the following individuals regarding my healthcare (Please provide their full name, relationship with you, and their phone numbers):

1. ____ __________________ _________________

2. ____ __________________ _________________

☐ ***May leave appointment reminders*** ☐ ***May leave lab results*** ☐ ***May leave general info***