Instructions Regarding Protected Medical Information

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1. RELEASE INFORMATION as follows:

______share (as with a consult) OR ______ transfer (I am withdrawing from this practice)

______**to HFM** from the source listed below OR ______**from HFM** to the location listed below.

____

____

____

Please, include ONLY **recent** (last 3 yrs?) or **cumulative** documentation ***relevant*** to my current or ongoing care. Hospital H and Ps, disch. summaries, vaccine records, medication and problem lists are most useful. (*Note: a request may be made for "all records in your possession" by initialing here ___________, but this is not usually helpful to either recipient or sender and may result in additional charges to the patient.)*

WITHOLD INFORMATION?
Unless crossed out or specified below, I give my **specific consent to release information regarding:**

HIV/AIDS STDs Reproductive Care Mental Health Alcohol/Drug Abuse **INITIAL HERE:** _____

Do NOT release the following information (describe by subject and/or date):_____________________________

____

NOTE: records will indicate *"material withheld at patient* request." Further, charges to the patient may be made for the time required to edit such records. **I understand that charges may apply. INITIAL HERE:** _____

2. CORRECT INFORMATION in my medical record as follows:_______________________________________

____

____

NOTE: *if HFM elects not to change the record, the above statement or another you provide will be included in any release of information to others. If more space is required write "see affixed."*

3. RESTRICT DISCLOSURE (do NOT share) regarding: ___ ALL or ________________________________

____ (e.g. a particular visit or subject),

TO the following person(s) (name and relationship) _____________________________________

BY (e.g. telephone, answering machine/service, mail), __________________________________, or

AT (e.g. do not call me at home, work), ____.

These instructions are to be honored until I change them.

Signature(s): ______________________________ ____________________________ Date: ______________

PRINTED NAME: __________________________________

WA requires the consent of those over the age of 13 for highly sensitive metrial. Please, both child and parent sign this form.

on behalf of (PRINT name of patient if form completed by another): ____________________________________

PATIENT: Birthday (mm/dd/yyyy): _____/______/___________ SSN:__________-______-___________