

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone(s): _____

I authorize Families First to release or obtain personal health information of the above-named individual to the person/facility named below. [] Release to [] Obtain from

Name/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

City, State, Zip: _____ Email: _____

For dates of care from: _____ to: _____

Purpose of release: _____

If leaving our practice, reason: _____

Please initial all types of information that you authorize us to release or obtain:

- Medical diagnostic, testing, and treatment information
Dental diagnostic, testing and treatment information and /or x-rays taken:
Records of immunizations and physicals
Current prenatal records, copies of all lab tests (including HIV results) and/or scans
Summary of labor and delivery notes for the following date of delivery:
Information about Sexually Transmitted Diseases and/or HIV/AIDS
Psychiatric/psychological evaluation(s), reports, assessments, summaries, psychotherapy notes or other documents with diagnosis, prognoses, recommendations, or testing records and behavioral observations.
Drug and alcohol information including evaluation, diagnostic, treatment and progress notes.
Other:

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person and/or secure e-mail

- I understand that I may revoke (withdraw) this authorization at any time by notifying Families First in writing. Revocation will be effective as of the date received.
I understand that a revocation will not apply to: 1) any actions that Families First has already taken while relying on this authorization before I revoke it; or 2) if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes.
I understand that the recipient of some information disclosed under this authorization may re-disclose this information and that the information will no longer be protected by federal privacy regulations.
I understand that I have the right to: 1) Inspect or copy the protected health information to be used or disclosed as permitted under Federal law; 2) Refuse to sign this authorization.
This authorization will remain in effect for one year and may be revoked at any time in writing.
Unless otherwise noted, only the past two years of electronic records as stipulated above will be sent.

Signature of Patient and/or Legal Representative: _____ Date: _____

To receiving provider: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For office use only: Witness: _____ Date: _____
Sent by: _____ Date: _____

FOR PATIENTS WHO ARE LEAVING FAMILIES FIRST

I. TRANSFER OF CARE QUESTIONNAIRE

We care what you think! We would like your feedback on the care you received while a patient at Families First and the reason for transferring your care. Please take a few minutes to complete the following questionnaire. Any suggestions and comments are appreciated. Thank you for your time.

1) Why are you leaving Families First? (Please check as many as apply.)

Moving: Please list town and state: _____

Change of Insurance*: Changed to: _____

If you checked this box, did you know Families First accepts private insurance?

Yes

No

Other: Please explain below (use separate page if needed):

2) Please answer these questions regarding office operations:

- | | | |
|--|------------------------------|-----------------------------|
| a. Were you able to reach us when you needed assistance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Were you able to make appointments when you needed them? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Was the length of time you waited at your appointment reasonable? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Was the staff responsive to your needs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

3) Would you recommend Families First to others for their health care needs? Yes No

4) Do you have any ideas or suggestions to improve the services at Families First?

Thank you for taking the time to complete the questionnaire. Your thoughts are valuable to us. If we can be of further assistance, please do not hesitate to call us.

II. IMPORTANT INFORMATION FOR PATIENTS WHO ARE LEAVING FAMILIES FIRST

1. We will be closing your case with our health center. If at any time you desire to return to the health center, we would be happy to welcome you back. Please call the office to re-establish care.
2. If you have family members who come to the health center and are also transferring their care, please tell us as soon as possible so we can cancel their future appointments as well. Please list their names here:

3. If you need additional information, please call Medical Records at 422-8208 ext. 3114.