Fredericksburg Christian Health Center
1129 Heatherstone Drive, Fredericksburg, VA 22407
Phone 540-785-8500 Fax 540-785-5328

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I UNDERSTAND THAT UNDER THE Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and care among multiple providers
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Provide information to referring physicians or other medical professionals providing treatment

I have received and reviewed Fredericksburg Christian Health Center's NOTICE OF INFORMATION PRACTICES (front page), which contains a more complete description of the uses, and disclosures of my health information. I understand that Fredericksburg Christian Health Center has the right to change its NOTICE OF INFORMATION PRACTICES from time to time and that I may contact them at any time to obtain a current copy.

I understand that I have the right to revoke this authorization in the future. In order to be effective, the request must be in writing and will take effect when both the patient and the practice have signed the revocation. The revocation must include the patient's name, address, phone number, patient signature, date the revocation submitted and reason for the request.

This authorization permits Fredericksburg Christian Health Center to discuss my Personal Health Information (PHI) with **ONLY** those individuals I have listed below (FCHC **CANNOT** discuss your PHI with anyone not listed below):

Spouse_____ Mother_____

Father_____ Adult Children_____

Other_____ Other_____

I may elect to have this authorization expire on a date I specify in the future. The date I have entered below represents the date I wish this authorization to expire:

☐ Check the box to the left if you do not wish this authorization to expire; however, I may notify the practice in writing at a future time with an expiration date.

DATE OF AUTHORIZATION EXPIRATION: _____/_____/_____

I fully understand and accept the terms of this authorization. I understand when the information used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information.

PATIENT NAME (print):_____DATE:_____

SIGNATURE OF PAITNET OR GUARDIAN:_____

OFFICE USE ONLY

Date Received:_____By:_____

Patient declined to sign the Authorization Form for the following reason:_____