NECAC Family Planning (Hannibal, Bowling Green, Warrenton, O'Fallon)

3518 Palmyra Road Hannibal MO 63401 **Phone: 573-221-3404 Fax: 573-221-0640**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I request and authorize NECAC Family Planning to release healthcare information of the patient named above to:

Doctor's Name: _____

Doctor's Phone: _____ Fax: _____

This request and authorization applies to information within the following dates:
2017-2022

Healthcare information that will be sent:
Most recent exam, test results, and contraceptive record

I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of these specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it. I understand that I may be charged for copies of my medical records.

I HAVE READ AND UNDERSTAND THIS CONSENT.
I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.

RELEASE MUST BE SIGNED BY PATIENT – NOT A PARENT OR GUARDIAN.

Patient's signature: _____ Date: _____

Prohibition of Redisclosure: This information has been disclosed to you from records that are confidential. You are prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the releases of medical or other information is not sufficient for this purpose.