



Instructions for Completing the Authorization for the Release of Confidential Information

To protect our patient's confidential medical information, we must have a valid, complete, and legible authorization to disclose their health information.

1. Patient Information - print the patient's:

- Full legal name
- Date of Birth
- Maiden name or any alias names
- Street Address and Phone number

2. Direction of Release: TO, FROM, TO AND FROM

- TO: If you select "To", The Family Development Center will share information/records with the individual/provider/organization listed.
- FROM: If you select "From", The Family Development Center will request information/records from the individual/provider/organization listed.
- TO AND FROM: If you select "To and From", The Family Development Center will both share and request information/records with and from the individual/provider/organization listed.

3. Individual/Provider/Organization Information

- Name: please provide the name of the individual, provider, and/or the organization (if applicable).
- Address: please provide a minimum of street address or City, especially if the organization has multiple locations.
- Phone number: provide a phone number in case we have questions or difficulty sending the release.
- Fax and/or Email address is required – provide at least one.

4. Date of Records

- Specific Date: will authorize the release of a specific record – provide the exact date.
- Range: will authorize the release of records within a date range – provide a to and from date.
- Most recent: will authorize the release of the most recent.
- All/Any: will authorize the release of all/any from your services at The Family Development Center.

5. Specific Type of Information to be Released: Check appropriate box(es) or write/type in if other purpose.

- Diagnostic Assessment
- Progress Notes
- Treatment Plan/Closing Summary
- Treatment Summary
- Contact Record
- Complete Client Record
- Billing/Statements
- Scheduling/Appointment Date(s)
- Other



6. Reason for Release of Information: Check appropriate box(es) or write/type in if other purpose. If you have an upcoming appointment that these records are needed for, please provide the appointment date.

7. Form or Format of Release: Check appropriate box(es) or write/type in if other purpose.

- Hard Copies – check this box if you are allowing paper copies of your information to be given to the individual/provider/organization listed. Be sure to indicate what information should be release in the Specific Type of Information to be Released section.
- Electronic – check this box if you are looking to have your information sent to the individual/provider/organization listed via an electronic form such as a secure portal or email. Also note that the recipient of the electronic release will need to have computer applications that allow them to view a PDF file.
- Fax – check this box if you are looking to have your information to the individual/provider/organization listed via fax.
- Verbal Exchange – Check this box if you are allowing verbal discussions of your health, billing, and/or scheduling information with parties listed.
- Other

8. Delivery Method: Please check the box to indicate how the records should be sent to the individual/provider/organization listed.

- Mail – if you check this box, please make sure you have a complete address for the individual/provider/organization listed.
- Encrypted Email – check this box for
- Fax – check this box for continued care release only and be sure to include a fax number for the individual/provider/organization listed.
- Pick up by patient/designee – check this box if you want to have the information picked up. Whomever you would like to pick up the information will need to be listed as the individual/provider/organization listed (if someone other than client). The person picking up the information will need to have a valid photo identification card.

9. Authorization/Revocation: This authorization will terminate one year from the date signed unless you specify an earlier date. Any medical information after the date of signature will not be released. If you need to have your information sent after the date signed on this form, please complete a new form. The patient or legal representative must sign and date the authorization in order for it to be valid. If a legal representative signs we will need a copy of a document showing legal representation.

10. There may be a charge for records.

Case Summaries	\$25.00
ROI for Medical Records	\$1.41/page*
Plus Retrieval Fee	\$18.80*
Plus cost of postage	per weight

** Whether fees may be charged for client medical records, and the amount of any fees, may vary based on the individual situation. For instance, a client may request, at no cost, a copy of their records for the purpose of reviewing current medical care.*

If help is needed to complete this form, you should contact your provider. If your provider is no longer with The Family Development Center, you can contact medicalrecords@thefamilydevelopmentcenter.com.