Metropolitan Family Care, Inc.

3341 East Livingston Avenue, Suite D

Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

**2014**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Metropolitan Family Care, Inc. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

* I understand that I have the right to revoke this authorization in writing at any time.
* I understand that it is **MY RESPONSIBILITY** to make Metropolitan Family Care, Inc. aware of any changes to this consent.
* I understand that certain information cannot be release without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

\_\_\_\_\_ Information regarding the patient’s diagnosis and treatment of HIV/AIDS

\_\_\_\_\_ Psychotherapy notes from a Psychiatrist or Psychotherapist.

\_\_\_\_\_ Treatment for alcohol or drug abuse reports.

\_\_\_\_\_ **I DO NOT AUTHORIZE** Metropolitan Family Care, Inc. to release any or all information concerning my medical care to any individual except as set forth above.

\_\_\_\_\_ **I AUTHORIZE** Metropolitan Family Care, Inc. to verbally release any or all information concerning my medical care to the following individuals.

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| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Patient Signature Date |