The Family Center of Hope ("TFC, Inc.")

2902 George Washington Memorial Highway, Hayes, VA 23072
Phone: 804-684-2555; Fax: 804-642-6722

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Section A (Must be Completed In Full for All Authorizations)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations.

Patient Name:_____**ID#**_____

Persons/Organizations Providing My Information

_____
_____
_____

Persons/Organizations Receiving My Information

The Family Center of Hope
P.O.Box 752
Hayes, VA. 23072

Specific Description of My Information and Dates of Service To Be Released:

_____
_____
_____
_____

Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure?_____
_____

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [ ] YES [ ] NO

The patient or the patient's representatives must read and initial the following statements:

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:**_____

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:**_____

Section C (Must be Completed In Full for All Authorizations)

The patient or patient representative must read and initial the following statements:

I understand that this authorization will expire on _____/_____/_____ (DD/MM/YR) **Initials:**____

I understand that I may revoke this authorization at any time by notifying TFC, Inc. in writing and if I do revoke it, it won't have any effect on any actions they took before they received the revocation. **Initials:**___

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient (Brother, Sister or Self)

_____ _____
Signature Date