RELEASE OF INFORMATION

Family Care Associates
Of Blair County
DBA Quantum HealthCare
Services LLC
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Phone: 582-465-7008

ENTITY TO RELEASE INFORMATION

Entity Name:

_____

Phone: _____ Fax:

_____

Address:

_____

I authorize the following information to be released from my medical record:

- ❑ Medical history and current health status
- ❑ Diagnosis and treatment information
- ❑ Medication list and/or allergies
- ❑ Laboratory and test results
- ❑ Imaging studies (X-rays, CT scans, MRIs, etc.)
- ❑ Immunization records
- ❑ Insurance information and billing records
- ❑ Other: _____

Service date (or date range):

_____

ENTITY TO RECEIVE INFORMATION

**If patient is the recipient, write "self" for Entity Name and complete the information needed to complete the transfer.*

Entity Name:

_____

Phone: _____ Fax:

_____

Address:

_____

❑ Fax ❑ Mail ❑ CD / Flash Drive ❑ Email (secure) ❑ Patient Pickup ❑ Courier

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Patient Name (Print): _____ DOB:

_____

I, the above-named patient, authorize the entity named to release or disclose my health information, which may include information related to psychiatric impairment, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or tests for / infection with Human Immunodeficiency Virus (HIV).

Patient Signature: _____ Date:

_____

Representative Name: _____ Relationship:

_____

Provider Signature: _____ Date:

_____

VERBAL AUTHORIZATION (for patients physically or cognitively unable to sign)

Witness #1 Signature: _____ Date:

_____

Witness #2 Signature: _____ Date:

_____