Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this authorization form, you are agreeing to the release or disclosure of your protected health information. Your medical care or payment for care will not be conditioned on the signing of this form.

Please be aware that any information disclosed to a third party pursuant to this authorization may be subject to re-disclosure and no longer protected by our policies and applicable law.

This authorization will expire one year from the date of the signature below. You have the right to revoke this authorization by completing the revocation section below. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release my protected health information to:

❑ FCHC Primary Care Delta ❑ FCHC Primary Care Fayette ❑ FCHC Primary Care Wauseon
 6696 US Highway 20A 124 W Main St, PO Box 399 735 S Shoop Ave
 Delta, OH 43515 Fayette, OH 43521 Wauseon, OH 43567
 Phone: 419-822-3242 Phone: 419-237-2501 Phone: 419-335-3242
 Fax: 419-822-9008 Fax: 419-237-2671 Fax: 419-335-3222

❑ FCHC Orthopedics ❑ FCHC OB/GYN ❑ FCHC Pediatrics
 735 S Shoop Ave 725 S Shoop Ave 725 S Shoop Ave
 Wauseon, OH 43567 Wauseon, OH 43567 Wauseon, OH 43567
 Phone: 419-335-2663 Phone: 419-335-6377 Phone: 419-335-3333
 Fax: 419-335-9615 Fax: 419-335-6807 Fax: 419-337-7845

❑ FCHC Behavioral Health ❑ FCHC General Surgery ❑ FCHC Urology
 725 S Shoop Ave 725 S Shoop Ave 725 S Shoop Ave
 Wauseon, OH 43567 Wauseon, OH 43567 Wauseon, OH 43567
 Phone: 419-330-2790 Phone: 419-337-7478 Phone: 419-335-2000
 Fax: 419-330-2774 Fax: 419-337-7846 Fax: 419-335-7500

❑ FCHC Urgent Care ❑ FCHC Cardiology ❑ FCHC Ear, Nose & Throat
 735 S Shoop Ave 725 S Shoop Ave 725 S Shoop Ave
 Wauseon, OH 43567 Wauseon, OH 43567 Wauseon, OH 43567
 Phone: 419-337-7467 Phone: 419-335-330-2769 Phone: 419-335-3712
 Fax: 419-337-7468 Fax: 419-330-2738 Fax: 419-335-3713

The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/or substance abuse and mental illness.

Information and date(s) of service to be disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose for disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 (Patient or Representative)

**\*\*\*Revocation\*\*\* (Sign below ONLY if you wish to revoke this authorization)**

I hereby revoke this authorization

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 (Patient or Representative)