Transfer of Medical Information

Permission to get records

I, _____,with a date of birth,_____, give my permission for
(patient name) (patient's DOB)

Focus on Relationships, Inc to give my medical records in their entirety to The Provision School and Family Counseling Center, Inc so that my condition can be better understood and appropriate treatment provided.

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for any and all records to be transferred that may contain information about:

- ❑ my mental health,
- ❑ transmittable disease I may have like HIV/AIDS,
- ❑ genetic records, and/or
- ❑ drug and alcohol records.

I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.

_____

Patient's Signature Date

_____

Authorized Representative's Signature Date

_____

Relationship of Authorized Representative