Family Focus, Inc
Authorization for Release of Medical Records / Protected Health Information

Patient Name ____ Patient Date of Birth _____________________________

I authorize ____ of Family Focus, Inc. to:

□ Release confidential and non-confidential information to:

□ Obtain confidential and non-confidential information from:

□ Exchange confidential and non-confidential information with:

____
Company / Provider / Person **Name**

____
Company / Provider / Person **Phone** Company / Provider / Person **Fax**

____
Other

Type of Request: □ Medical Record Request □ Authorization to Communicate

Information being released / requested:

Covering the period(s) of treatment from _________________ to _________________. □ ALL

□ Phone conversation	□ Clinical Notes	□ Labs / Medication
□ Diagnosis	□ Billing Information	□ Other: _______________
□ Testing Report	□ Dates of Service	□ ALL

Records include psychological, educational, medical, sociological, and psychiatric information in both written and spoken form. I authorize Family Focus, Inc. to release and/or obtain confidential information in both written and spoken form to the person(s) noted above. I freely and knowingly consent to waive any rights I may have to confidentiality of communications and records for the above stated purpose. I understand that I may revoke this consent to release of information at any time.

Copying / Processing Fee Schedule

Family Focus, Inc. assesses the following copying and/or processing fees for client medical records. Medical records will be released once medical record copying / processing fees are paid in full. We accept cash/charge/check payment. Please allow 15 calendar days for processing.

- Copying fee of $.50 cents per page, up to 50 pages; Additional fee of $.25 cents per page, for 50 or more pages
- Processing fee of $5, if records exceed 15 pages; Processing fee of $10, if records exceed 25 pages
- Postage fees (TBD), if records are being mailed
- We reserve the right to charge a records fee equal to or greater than $6.50 in the event that records are delivered electronically via our encrypted email server.

Printed Patient Name: ____

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Signature of Patient or Parent / Guardian Date

****This form must be accompanied with the patient's valid photo ID in order to process****