FAMILYFIRST
PRIMARY CARE

I authorize Family First Primary Care, PLLC to use and disclose a copy of the specific health and medical information described below.

Name of Patient: _____
DOB/SSN: _____

Description of information on above named patient to be used disclosed:
_____
_____
_____

Name of Recipient: _____

Purpose of Disclosure: _____
_____
_____

If Family First Primary Care requests this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:
1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this authorization, and
4. We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed o complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law.

By: _____ Date:_____
(Patient)

Or By: _____ Date: _____
(Patient's Representative)

Description of Representative's Authority _____
_____
_____