FOUNDATION FOR MEDICAL CARE
OF TULARE & KINGS COUNTIES, INC

DC6006-20221026

Return completed form to:

Foundation for Medical Care
3335 S Fairway
Visalia, CA 93277

OR Fax: 559-468-3140

Protected Health Information (PHI) Authorization Form

Note: If this authorization is signed by the patient's representative, attach a statement of the representative's authority to act on behalf of the individual.

Member Information (Person whose information will be released):

Name:____ Date of birth:_____/_____/_______

Address:____

Member ID#___________________ Health Plan:____________________ Phone#____-____-______

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for plan benefits or my ability to obtain treatment or payment.

☐ **Full Disclosure**: Any protected health information Foundation for Medical Care and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records.

☐ **Limited Disclosure**: You specify what PHI to share. Ex.condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. If Limited Disclosure was selected please indicate which product(s) apply:

____

☐ Medical and/or Prescription coverage ☐ Vision ☐ Dental

Legal Representative (Person or Orginization Representing the Member):

Name:____ Date of birth:_____/_____/_______

Or if an Orginization:____

Address:____

Email:____ Phone#____-____-______

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Orginization

I understand that I may revoke this authorization, at any time, by sending a written request to the privacy contact identified below. I am aware that a revocation will not have any effects on any use or disclosure to Protected Health Information (PHI) by the Plan before it receives the reaction.

This authorization expires on _____/_____/_______ or until revoked in writing.

Member or Legal Representative Signature:_____________________________ **Date:**_____/_____/_______