



Friends in Adoption

Medical Release

653 Plank Road, Suite 200
Clifton Park, NY 12065
1-800-98-ADOPT (1-800-982-3678)
Fax (518) 371-9936
www.friendsinadoption.org

PLEASE FILL OUT AND RETURN TO FRIENDS IN ADOPTION IN THE ENCLOSED ENVELOPE. THANK YOU.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Medical Provider's Name: _____

Medical Provider's Address: _____

Medical Provider's Phone: _____ Medical Provider's Fax: _____

Dear Medical Provider:

I am considering making an adoption plan with Friends In Adoption ("FIA"). Please copy and forward my medical records to them at your earliest convenience. FIA will be happy to reimburse any copying costs. Thank you.

- I, _____ give my consent to have my medical records released and forwarded to Friends In Adoption. I also give FIA permission to forward these records to the prospective adoptive family, and all other relevant parties.
- I, _____ give my consent to have the results of my HIV test released and forwarded to Friends In Adoption. I also give FIA permission to forward these records to the prospective adoptive family, and all other relevant parties.
- I, _____ also authorize the release of my Medicaid/Insurance information to Friends In Adoption. I give FIA permission to release and forward this information to all relevant parties.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to _____.
- I understand that revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire within six months after the birth of my baby.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect a copy of the information to be used or disclosed, as provided in CFR 167.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____.

This authorization is intended to constitute a release of privileged communication and a request for the cooperation of the above-named addressee. Consequently, you are authorized to discuss my medical condition and medical records with Friends In Adoption, in addition to providing them with the above described records and documents.

SIGNATURE OF PATIENT

DATE