



**MEDICAL RECORDS
REQUEST / RELEASE**



AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: ____ / ____ / ____

I hereby give authorization for the use or disclosure of the above individual's health information as described:

1. Released **From:** Urgent Care of Holden

Released **To:** Urgent Care of Holden

To (complete below) via protected fax:

From (complete below) via protected fax:

Facility / Provider _____

Street Address _____

City / Town _____ State _____ Zip _____

Phone # (_____) _____ – _____ Fax # (_____) _____ – _____

2. **Type of information to be used or disclosed** (check all that may apply):

All Medical Records types on file

Radiology Reports

Visit Encounter Providers Chart Only

Laboratory Test Results

3. **Including any of the following related confidential information protected under state law** (check all that may apply):

Reportable Sexually Transmitted Diseases

HIV / AIDS results

4. **Dates of service requested** (check one):

All Service Dates on File

Specific date(s): _____

5. **The information I am authorizing disclosure for will be used for the following purpose** (check all that may apply):

Appointment with Specialist

Attorney / Legal Purposes

Continued / Coordination of Care

My Personal Use

I understand that:

- This authorization is voluntary. Any disclosure carries the potential for unauthorized re-disclosure. I release Urgent Care Specialists, PC d/b/a Urgent Care of Holden from any legal liability that may arise from the disclosures or re-disclosure of this information.
- Unless otherwise revoked, this authorization will be valid for only ninety (90) days from the date of signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.
- I have read and understand the above statements and authorize the disclosure of the information requested:

Signature of Patient / Parent / Legal Representative

Date

Signer's Relationship to Patient

Signature of Staff Member Releasing PHI

Date

Time

AM PM