physicians
immediate care™

REQUEST TO RELEASE MEDICAL RECORDS

Tell us about yourself.

Patient Name	Social Security Number	Birth Date (MM/DD/YYYY) / /
Mailing Address	City, State, Zip	Phone ( )

Who should receive the information?

The information is to be disclosed by:	And is to be provided to:
Name of Facility PHYSICIANS IMMEDIATE CARE	Name of Person, Organization or Facility
Clinic City, State	Address
	City, State, Zip

What is the purpose or use for this information?

❑ Further Medical Care ❑ Attorney ❑ Insurance ❑ School
❑ Personal Use ❑ Disability ❑ Research ❑ Other _____

What is the specific information that should be disclosed?

❑ Only information from (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____
❑ Only information related to: (specify diagnosis, injury, therapy, etc.) _____
❑ Other information: (specify billing, radiographic images or reports, etc.) _____
❑ Entire record

Can sensitive information be disclosed?

X ❑ Yes. I authorize the release of information about alcohol or substance abuse, HIV/AIDS or mental health.
❑ No. I DO NOT authorize the release of information about alcohol or substance abuse, HIV/AIDS or mental health.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Do you want us to share your protected health information?
I hereby authorize use or disclosure of protected health information about me as described in this form. I understand that the health information that is used or disclosed pursuant to this authorization may be redisclosed by the person(s) or facility receiving the information and may no longer be protected by federal or state privacy laws. I may revoke this authorization by notifying Physicians Immediate Care in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

When does the authorization expire?
This authorization expires on (MM/DD/YYYY) _____

Are there fees for copies?
Federal and state laws permit a fee to be charged for the copying of patient records. Physicians Immediate Care has contracted with HealthPort to make copies. You may be required to pre-pay for copies; if not, then your copies will be mailed with an invoice.

I have read, understand and agree to the AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION terms, conditions and authorization described above and understand its purpose and content.

X _____ Signature of Patient _____ Today's Date

_____ Print Name of Guardian or Personal Representative of Patient's Estate
_____ Signature of Guardian or Personal Representative of Patient's Estate
_____ Description of Authority to Act for the Patient

FAX FORM TO: ❑ _____ CLINIC ❑ (815) 633-6625 CIOX

OFFICE USE ONLY: Copy Given to Patient _____

