HealthcareOne
Urgent Care and Family Practice

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Authorization to Release/Request for an Individual's Health Information or Treatment/Education Records

Last Name: _____ First Name: _____ Middle: _____

Other Names Used: _____ Date of Birth: _____ SSN# _____

Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the provider named below to the recipient named below.

□ Most recent Progress Notes
□ Pathology/Lab Reports
□ X-ray Reports/Films
□ Current medication record
□ Discharge Summaries
□ Billing Records
□ Immunization Records
□ Entire Health Record *(Excludes Psychotherapy Notes)
□ Work Comp Records only _____
□ Other _____
□ Psychotherapy Notes (if checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information must be completed)*

☐ I will pick up copies of my records ☐ Fax to person stated below ☐ Mail copies to the person stated below

Records From:	**Records To:**
Name:	Name :
Department:	Department:
Address:	Address:
City: State : Zip :	City: State: Zip:
Phone: Fax:	Phone : Fax:

Purpose of Request: ☐ patient's request, ☐ dispute, ☐ referral, ☐ New PCP, ☐ other: _____

I understand:
I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be twelve (12) months from the date of signature.

Unless the purpose of this authorization is to determine payment of a claim or benefits Healthcare One Urgent Care and Family Practice may not condition the provision of treatment or payment for my care on my signing the Authorization.

Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NON COMMUNICABLE DISEASE.

*The information authorized for release may include protected health information and/or a student treatment/; education records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the Information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

_____ _____ _____
Signature of Patient, parent, or Legal Authorized Representative** Relationship to Patient Date

** May be requested to show proof of representative status.