Alamo City Urgent Care

Authorization to Use or Disclose Protected Health Information
Medical Record Release

Patient Name: _____DOB: ____/____/_____ SS #: _____/_____/_____

Patient Address: _____ St: _____ Zip Code: _____

Requestor Name: _____ Date Requested: _____/_____/_____

Requestor Address: _____ St: _____ Zip Code: _____

Phone: _____/_____/_____ Fax: _____/_____/_____ Email: _____@_____

Purpose: □Patient Request □Legal Purposes □Other _____

Information Requested □All Dates of Service □Specific Date of Service: _____ to _____

□Entire Medical Record □History/ Physical □Progress Notes □EKG Reports

□Laboratory Reports □Radiology Reports □Discharge Summary □Accounting/Billing

□HIV Testing □Chemical Dependency □Other _____, _____

□ I authorize the company to use and disclose my PHI to the above specified requestor. This authorization is valid for 6 months from the date signed and may be revoked at any time per the Written Specific Request to Exercise My Patient Rights form. I understand that revocation will not pertain to information that has already been released.

□ I give my specific authorization for the company to use and disclose my PHI for purposes not covered in the Notice of Privacy Practices which may include information pertaining to chemical dependency, HIV, genetic or psychiatric information.

□ I understand that I may refuse to sign the authorization and this refusal will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits.

□ I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Signature: _____ **Date:** _____/_____/_____
(Patient or Authorized Representative)

A copy of this Authorization is as valid as the original and you have a right to receive a copy if requested.

Company Use Only

□The Company has accepted the request for PHI. The information has been sent via □Mail □Fax □Email □Other_____
□The Company is unable to comply with your request at this time for the specified reasons. _____

Signature: _____ **Date:** _____/_____/_____
(Medical Record Department Representative)