URGENT CARE of Wilbraham
Bringing ER expertise to life's little emergencies
2040 Boston Road, Wilbraham MA 01095
Phone 413-599-3800 – Fax 413-279-1900

MEDICAL RECORDS REQUEST FORM

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 Wilbraham
To (complete below) via protected fax:

☐ Released **To**: Urgent Care of Wilbraham
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
☐ Visit Encounter Providers Chart Only
☐ Other: _____
☐ Radiology Reports
☐ 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
☐ My Personal Use
☐ Continued / Coordination of Care
☐ Other: (Please describe) _____

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 Wilbraham 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***