AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at_____

In the city of _____ in the state of _____ zip code _____

Phone number _____hereby authorizes:

PRIMACARE MEDICAL CENTERS

To disclose the following specific medical information to: by: ☐ mail or ☐ fax _____

Name: _____
(SELF, PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: _____

City, State, Zip: _____

My authorization extends only to those data elements / documents initialed below:

_____ Records of visits (all visits)

_____ Record of visit for a specific date or dates Specific dates include or are limited to: _____

_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

_____ All of the above

_____ Other (Must be specific) _____

_____ Mental Health and/or alcohol and drug abuse treatment

_____ HIV information

_____ Hepatitis Information

PRE PAYMENT IS REQUIRED - YOU WILL BE CONTACTED WITH AMOUNT PRIOR TO SENDING RECORDS
FEES: $25.00 for the first 20 pages plus $0.50 for each page thereafter and $8.00 per x-ray film

Purpose of this disclosure is:
_____ Continuing Medical Care _____ Military _____ Social Security / Disability _____ School

_____ Legal Purposes _____ Insurance _____Personal Use Other _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original
3. I may revoke this authorization at any time by completing PrimaCare's revocation of authorization form, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.

_____ _____
(PATIENT'S NAME PRINTED) DATE

_____ _____
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) REVOCATION DATE (IF OTHER THAN 60 DAYS FROM DATE ABOVE)

_____ _____
SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY) PATIENT DATE OF BIRTH

_____ _____
WITNESS DATE