EFFINGHAM PromptCare Primary & Urgent Care

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RECORDS RELEASE FORM

PATIENT INFORMATION

Last Name: **First Name:** **Middle Initial:** **Previous Names:**

Date of Birth: **Social Security Number:** **Daytime Phone:**

MEDICAL OFFICE INFORMATION

I request and authorize Effingham Prompt Care to: *(Please Select One)*

☐ Obtain Records From ☐ Release Records To

Medical Office: **Phone Number:** **Fax Number:**

MEDICAL RECORDS RELEASE

You may use or disclose the following health care information (check all that apply): *(Please Select One)*

☐ All Records

☐ Labs / Pathology ☐ Most Recent Specialist(s) Visit ☐ Chart Notes

☐ X-rays / Diagnostics ☐ Patient Visit Summary ☐ Billing

Other: **Time Frame Requested:**

Method of delivery: *(Please Complete One)*

Pick Up: **Faxed:**

Emailed: **Mailed:**

Reason for Authorization: *(Please Select One)*

☐ At the request of the individual ☐ Other

Expiration: *(Please Select One)*

☐ At the request of the individual ☐ Other

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized Effingham Prompt Care to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to Effingham Prompt Care, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SIGNATURES

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____