**Primary Care Services, S.C.**
2500 S. Highland Ave., Suite 230,
Lombard, IL 60148-5363

Phone:(630) 429-9000
Fax:(630) 429-9060

my-primarycare.com

# AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

| **SECTION: 1 - Patient Information (please print and complete ALL blanks)** | |
|---|---|
| First Name: _____ | Last Name:_____ |
| Previous Name: _____ | Phone #:_____ |
| Date of Birth: _____ | Social Security #: _____ |
| Address: _____ | City/State/ZIP: _____ |

**SECTION 2: Information Requested (please check all appropriate boxes)**

☐ Healthcare information relating to the following treatment, condition, or dates:
_____

☐ All healthcare information - All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ SPECIFIC Department/Physician/Clinic Location:_____

| | | |
|---|---|---|
| ☐ Radiology Reports | ☐ Radiology Images | ☐ Cardiac Testing |
| ☐ Labs | ☐ Medication List | ☐ Immunizations |
| ☐ Physical Therapy | ☐ Progress Notes | ☐ Other: _____ |

**Sensitive Records**

| | | | |
|---|---|---|---|
| ☐ Mental Health | ☐ HIV/AIDS/STD | ☐ Genetic Testing | ☐ Drug/Alcohol Abuse |

Witness signature is required for the release of these sensitive record types; for a minor aged **12-17** the minor's signature is required for the release of Mental Health, HIV/AIDS/STD or Drug/Alcohol Abuse records.

**Initials:** _____

**SECTION 3: I authorize Primary Care Services to release the above patient records to:**

Name of Individual/Organization:_____

| | |
|---|---|
| Phone: _____ | Fax: _____ |
| Address: _____ | City: _____ |
| State: _____ | ZIP: _____ |

**SECTION 4: Method of Delivery**

| | |
|---|---|
| ☐ Fax #: _____ | ☐ US Mail |

☐ Call for pick up by patient or legal representative
(pickup in ☐ Lombard or ☐ Glendale Heights – select one). A photo ID is required for pick up.

**SECTION 5: Purpose of Disclosure (records are subject to charges)**

| | | |
|---|---|---|
| ☐ Continuation of Care | ☐ Personal Reasons | ☐ Insurance |
| ☐ Legal | ☐ Other:_____ | |

**SECTION 6: Signatures**

- I understand, I have the right to revoke this authorization in writing at any time by sending revocation to Primary Care Services, (PCS) at the address listed above. The revocation will not apply if PCS has already taken action in reliance on the authorization.
- I understand, I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- I understand, that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand, I have the right to refuse to sign this authorization and PCS does not condition treatment on this authorization, except disclosure necessary for payment of claims or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).
- I understand, this authorization will expire in **90** days or upon the following specified date or event.

**I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.**

**Patient Signature:**_____ **Date:** _____

**Representative Signature (for minor, etc.):** _____

| | |
|---|---|
| **Relationship:**_____ | **Date:**_____ |
| | |
| **Witness Signature:***_____ | **Date:**_____ |

*Witness signature required for any sensitive records to be released if so selected in Section 2