



Primary Care Services, S.C.

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Lombard, IL 60148-7103

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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: _____

<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Cardiac Testing
<input type="checkbox"/> Labs	<input type="checkbox"/> Medication List	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Other: _____

Sensitive Records

<input type="checkbox"/> Mental Health	<input type="checkbox"/> HIV/AIDS/STD	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Drug/Alcohol Abuse
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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	
<input type="checkbox"/> Fax #: _____	<input type="checkbox"/> US Mail
<input type="checkbox"/> Call for pick up by patient or legal representative (pickup in <input type="checkbox"/> Lombard or <input type="checkbox"/> Glendale Heights – select one). A photo ID is required for pick up.	
SECTION 5: Purpose of Disclosure (records are subject to charges)	
<input type="checkbox"/> Continuation of Care	<input type="checkbox"/> Personal Reasons
<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal
<input type="checkbox"/> Other: _____	
SECTION 6: Signatures	
<ul style="list-style-type: none"> • 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	