HIPPA Authorization to Release Patient Information

GoWell URGENT CARE

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Names Used** _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address listed below:

   Name _____

   Address _____ Telephone _____

   City _____ State _____ Zip Code _____ Fax or Email Address for Delivery _____

3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization Records Only

   ☐ Service Dates Only: _____ to _____ ☐ Specific Information Only: _____

Sensitive information:
Unless excluded below, this authorization includes information related to alcohol/substance use, HIV/AIDS, and mental health treatment. Psychotherapy notes are never included.

☐ **PLEASE EXCLUDE** the following information from this authorization: _____

_____ **Signature:** _____

NOTES:

1. IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.**
2. I understand that I have the right to receive a copy of my PHI in the form, format, and manner I request, if readily producible in that way, or as I may otherwise agree. If I do not specify a format below, I understand that my PHI will be mailed to me at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format: ☐via secure electronic delivery; or ☐other (please specify): _____.
3. If I have requested records be sent unencrypted, I understand and acknowledge the risks of sending my PHI in an unsecured manner.
4. If I have requested records be mailed to me, I understand that I will be charged for the cost of paper and postage. If I request my records on a USB drive or similar device, I will be charged the cost of that device.
5. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or entity receiving it and may no longer be protected by federal privacy regulations.
6. I understand that I may revoke this authorization at any time by notifying my provider or GoWell Urgent Care in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
8. My purpose/use of the information is for ___ personal use; or ___other (please specify): _____.
9. This authorization expires on _____, 20___, or upon the occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of my information (please describe/specify event): _____. If no expiration date or event is provided, this authorization will expire one (1) year from the date signed.

Signature of Patient	**Date of Patient's Signature**	**Patient's Date of Birth**
If the patient is unable to sign, a legal guardian or personal representative of the patient's estate must sign above.	Signature of Legal Guardian or Personal Representative	Date / Description of Authority to Act on behalf of the Individual

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.