URGENT CARE of Wilbraham

Bringing ER expertise to life's little emergencies

2040 Boston Road, Wilbraham MA 01095
Phone 413-599-3800 – Fax 413-279-1900

MEDICAL RECORDS REQUEST FORM

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ DOB: _____ / ______ / _________

I hereby give authorization for the use or disclosure of the above individual's health information as described:

1. ☐ Released **From**: Urgent Care of Wilbraham
   To (complete below) via protected fax:

   ☐ Released **To**: Urgent Care of Wilbraham
   From (complete below) via protected fax:

Facility / Provider ____

Street Address ____

City / Town ____________________ State ________ Zip __________

Phone # (________) ________ — __________ **Fax # (________) ________ — __________**

2. **Type of information to be used or disclosed** (check all that may apply):
   - ☐ All Medical Records types on file
   - ☐ Radiology Reports
   - ☐ Visit Encounter Providers Chart Only
   - ☐ Laboratory Test Results
   - ☐ Other: ____

3. **Including any of the following related confidential information protected under state law** (check all that may apply):
   - ☐ Reportable Sexually Transmitted Diseases
   - ☐ HIV / AIDS results

4. **Dates of service requested** (check one):
   - ☐ All Service Dates on File
   - ☐ Specific date(s): ______________________________

5. **The information I am authorizing disclosure for will be used for the following purpose** (check all that may apply):
   - ☐ Appointment with Specialist
   - ☐ Attorney / Legal Purposes
   - ☐ My Personal Use
   - ☐ Continued / Coordination of Care
   - ☐ Other: (Please describe) ______________________________

I understand that:

- This authorization is voluntary. Any disclosure carries the potential for unauthorized re-disclosure. I release Urgent Care Specialists, PC d/b/a Urgent Care of Wilbraham from any legal liability that may arise from the disclosures or re-disclosure of this information.
- Unless otherwise revoked, this authorization will be valid for only ninety (90) days from the date of signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.
- I have read and understand the above statements and authorize the disclosure of the information requested:

______________________________ ____________ ______________________________

Signature of Patient / Parent / Legal Representative **Date** ***Signer's Relationship to Patient***