



**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I \_\_\_\_\_ who resides at \_\_\_\_\_

In the city of \_\_\_\_\_ in the state of \_\_\_\_\_ zip code \_\_\_\_\_

Phone number \_\_\_\_\_ hereby authorizes:

**PRIMACARE MEDICAL CENTERS**

To disclose the following specific medical information to: \_\_\_\_\_ by:  mail or  fax \_\_\_\_\_

Name: \_\_\_\_\_  
(SELF, PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**My authorization extends only to those data elements / documents initialed below:**

- \_\_\_\_\_ Records of visits (all visits)
- \_\_\_\_\_ Record of visit for a specific date or dates    Specific dates include or are limited to: \_\_\_\_\_
- \_\_\_\_\_ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
- \_\_\_\_\_ All of the above
- \_\_\_\_\_ Other (Must be specific) \_\_\_\_\_
- \_\_\_\_\_ Mental Health and/or alcohol and drug abuse treatment
- \_\_\_\_\_ HIV information
- \_\_\_\_\_ Hepatitis Information

**PRE PAYMENT IS REQUIRED - YOU WILL BE CONTACTED WITH AMOUNT PRIOR TO SENDING RECORDS**  
**FEES: \$25.00 for the first 20 pages plus \$0.50 for each page thereafter and \$8.00 per x-ray film**

**Purpose of this disclosure is:**

- \_\_\_\_\_ Continuing Medical Care    \_\_\_\_\_ Military    \_\_\_\_\_ Social Security / Disability    \_\_\_\_\_ School
- \_\_\_\_\_ Legal Purposes    \_\_\_\_\_ Insurance    \_\_\_\_\_ Personal Use    Other \_\_\_\_\_

**This authorization is given freely with the understanding that:**

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original
3. I may revoke this authorization at any time by completing PrimaCare's revocation of authorization form, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.

\_\_\_\_\_  
(PATIENT'S NAME PRINTED)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

\_\_\_\_\_  
REVOCATION DATE (IF OTHER THAN 60 DAYS FROM DATE ABOVE)

\_\_\_\_\_  
SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

\_\_\_\_\_  
PATIENT DATE OF BIRTH

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE