PRIMARY CARE ASSOCIATES

6840 Windsor Ave.
Berwyn, IL 60402
(708) 484-0042

REQUEST TO INSPECT, RELEASE, AND COPYING OF PROTECTED HEALTH INFORMATION From PRIMARY CARE ASSOCIATES

SECTION A: Individual requesting access.

Name:_____

Date of Birth_____ Telephone: _____

Address:_____

If this request is by a personal representative on behalf of the individual, complete the following:
Personal Representative's Name/Relationship to above individual

_____

PHYSICIAN OR FACILITY RECEIVING INFORMATION (Recipient):

Name:_____

ADDRESS:_____

Phone#_____Fax#_____

SECTION B: Please read the following and complete the information requested.

Disclosure will include (check *whole record* **or** all that apply):

___ Whole record ____ all records from: ___/___/____ to ___/___/____
___ Immunization report ____ Laboratory reports ____ X-ray/Radiology reports
___ Pathology reports ____ Progress/physician notes ___ Consult reports
___ ER/Hospital reports ____ Face sheet (current meds/problem list)
___ Growth Chart

I must check one or more of the following types of health information that I DO NOT want released to the above recipient. I understand that if I do not check any of the three (3) boxes, the health information released to the recipient may include any of the following:

___ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
___ Records of HIV/AIDS testing results, diagnosis, or treatment
___ Psychiatric, psychological records or evaluation and/or treatment for mental , physical or emotional illness

SECTION C: Reason or Purpose of Use for Protected Health Information.

_____

SECTION D: Expiration and Revocation. This authorization will expire on ____/____/_____,
SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.
I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and disclose to the recipient the protected health information described in this form. I understand that either Primary Care Associates or I may revoke this authorization at any time by giving written notice.

Signature: Date:

***There is a fee for copying medical records Amount Paid: _____