PLEASE MAIL OR FAX COMPLETED FORM TO:
Take Care Health Services
Attn: PSC – ROI Department
P.O. Box 691569, Orlando FL 32819
Phone: 855-925-4733 Fax: 888-297-8357

RELEASE OF INFORMATION
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Medical records are kept in strict confidence and are not released without the written authorization of the patient except as permitted or required by law. Take Care Medical Health New York, P.C., the providers at DR Walk-In Medical Care, have 30 days to respond to this request. I understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Release to: ☐ Insurance ☐ Physician ☐ Self ☐ Other: _____

If this form is being completed by patient or guardian a copy of your PHOTO ID is required

Name/Business: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

Please indicate the time period you are requesting records for. Dates of Service: from _____ to _____.

☐ Entire Medical Record
☐ Immunization records
☐ Physical forms
☐ Billing Information
☐ Lab/X-rays
☐ Other: _____
☐ Diagnosis/Treatment notes
☐ Referral

PURPOSE OF THE USE AND DISCLOSURE

☐ Diagnosis & Treatment
☐ Personal
☐ Legal
☐ Other: _____
☐ Insurance/Billing

PATIENT AGREEMENT

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not my health plan or my health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I release Take Care Medical Health New York, P.C., the providers at DR Walk-In Medical Care, Take Care Health Systems, LLC., Walgreen Co., and each of their respective subsidiaries, affiliated companies, directors, officers, employers, employees, attorneys, and agents from all legal responsibility and/or liability that may arise from the release of the records I have specified. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken with reliance on it. I authorize Take Care Medical Health New York, P.C., and its providers at DR Walk-In Medical Care to use or disclose of protected health information as described above.: _____
(expire date)

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Personal Representative Relationship to the patient and representative's authority to act on behalf of the patient

Revised 1.19.15