



**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. I understand that the Take Care Health Services providers at Healthcare Clinic at select Walgreens 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 \_\_\_\_\_.

- |  |   |
|--|---|
| <input type="checkbox"/> Entire Medical Record     | <input type="checkbox"/> Billing Information  |
| <input type="checkbox"/> Diagnosis/Treatment notes | <input type="checkbox"/> Immunization records |
| <input type="checkbox"/> Lab/X-rays                | <input type="checkbox"/> Referral             |
| <input type="checkbox"/> Physical forms            | <input type="checkbox"/> Other: _____         |

**PURPOSE OF THE USE AND DISCLOSURE**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Diagnosis & Treatment | <input type="checkbox"/> Legal    |
| <input type="checkbox"/> Insurance/Billing     | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Other: _____          |                                   |

**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 the Take Care Health Services providers at select Walgreens, 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 the Take Care Health Services providers at Healthcare Clinic at select Walgreens to use or disclose of protected health information as described above. This authorization will expire one (1) year from the date of signature or unless otherwise specified: \_\_\_\_\_

(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