Evans Urgent Care | Dr. Brett K. Wallentine, MD | 800 Oakhurst Drive Evans, GA 30809 | (706)364-5500

Authorization for Request of Health Information

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purpose.)

By signing this form, I authorize Evans Urgent Care, PC to request protected health information described below to:

Name of Person and/or Organization to Whom Information Should be Sent: _____

Secure Fax & Phone Number to which this form may be sent: _____

Address of Person/Organization to Whom Information Should be Sent: _____

_____

Please request this information on or about: ___/___/_____
This authorization expires upon fulfillment of request unless special circumstances noted below* Mo Day Year

Purpose of disclosure: ☐ Patients Request ☐ Other: _____

I authorize the following information to be sent to the address above:
_____ Copies of all medical records for the period: ____/____/____ to ____/____/____

_____ Copies of information described below for the period: ____/____/____

- History & Physical Exam
- Labs, X-Rays, Reports, etc.
- Reports from other Physicians
- Other (please specify): _____

I understand that this information may include any history of Acquired Immunodeficiency Syndrome (AIDS); sexually transmitted diseases; Human Immunodeficiency Virus (HIV); behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released even if occurring during the dates above: _____

_____

If requested, I have been provided with a copy of Evans Urgent Care's "Notice of Privacy Act Statement" and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Evans Urgent Care's Practice Manager.

I understand that Evans Urgent Care, PC assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Evans Urgent Care, PC from all legal liability that may arise from this authorization.

Patient's Printed Name: _____ Date of Birth: _____/_____/_____

Patient's Signature: _____ SSN: _____ - _____- _____ Date: ____/____/201___

Patient may revoke this authorization by notifying Evans Urgent Care in writing. Federal Law states that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited b by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to disclosure by the recipient.