

PRIMARY CARE ASSOCIATES

6840 Windsor Ave.
Berwyn, IL 60402
(708) 484-0042
(708) 749-5489
website: www.pricare.org

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION TO PRIMARY CARE ASSOCIATES

SECTION A: Individual requesting access.

Name: _____ Date of Birth _____
Address: _____
Telephone: _____ Social Security Number _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name/Relationship to patient: _____

PHYSICIAN OR MEDICAL FACILITY RELEASING PHI: _____

ADDRESS: _____

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

Sections of the medical record to be inspected copied : (Please mark the box)
Whole record All lab Tests Immunization/Growth charts Hospitalization records
from _____
All x-rays All Consults Specific items _____

SECTION C: Purpose of Use or Disclosure of Protected Health Information.

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire on ____/____/____, or with the occurrence of the following events:

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/or disclose to the persons and/or organizations named in this form the protected health information described in this form. I understand that I may revoke this authorization at any time by giving written notice. I understand that if I do not sign this form PCA may choose not to treat me.

Signature: _____ Date: _____