

PRIMARY CARE ASSOCIATES

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

REQUEST FOR AUTHORIZATION FOR INSPECTION, RELEASE, AND COPYING OF PROTECTED HEALTH INFORMATION

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 _____

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

If you chose to request a copy of your protected health information, a copy service retained by Primary Care Associates will copy and transmit your medical record. The copy service will charge you directly for their services regarding the copying of your medical record.

Sections of the medical record to be inspect copied : (Please mark the box)

Whole record All lab Tests Immunization/Growth charts Hospitalization records

from _____

All x-rays All Consults Specific Items _____

Please list **the name and address** of each person, including yourself or your personal representative, for whom you want us to make copies. If you want us to provide access to or copies of your records to any person other than you or your personal representative, you must provide us with a signed authorization. We can supply you with the appropriate authorization form.

1. _____ 2. _____

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: _____