PRIMARY CARE ASSOCIATES

6840 Windsor Ave.
Berwyn, IL 60402
(708) 484-0042
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 copied : (Please mark the box)

Whole record All lab Tests Immunization/Growth charts Hospitalization records

from___________________________________

All x-rays All Consults Specific item(s)____

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: ____