



HEALTH INFORMATION MANAGEMENT

Patient Authorization for Release of Health Information

HIPAA-Compliant Medical Records Release • 45 C.F.R. Parts 160 & 164

I, _____, hereby authorize **TrufaMED Urgent Care** to release my Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and any applicable state and federal privacy laws.

1 PATIENT INFORMATION

PATIENT NAME

DATE OF BIRTH

MRN (IF KNOWN)

PHONE NUMBER

EMAIL ADDRESS

2 INFORMATION TO BE RELEASED

- | | |
|---|---|
| ☐ Complete Medical Record | ☐ Imaging Studies (X-rays, CT scans, etc.) |
| ☐ Visit Notes / Clinical Summaries | ☐ Billing Records / Itemized Statements |
| ☐ Laboratory / Diagnostic Test Results | ☐ HIV / Sexually Transmitted Infection Testing Records |
| | ☐ Other: _____ |

DATE RANGE

(BLANK = ALL)

FROM

TO

3 PURPOSE OF DISCLOSURE

- | | |
|--|--|
| ☐ At my personal request / personal records | ☐ Workers' compensation |
| ☐ Continuity of care with another provider | ☐ Employment or school purposes |
| ☐ Insurance review or claims processing | ☐ Research (IRB-approved) |
| ☐ Legal proceedings or attorney review | ☐ Other: _____ |

**4 RELEASE TO** _____

NAME OF RECIPIENT / ORGANIZATION _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE _____

FAX _____

EMAIL _____

Preferred Delivery: ☐ Mail ☐ Fax ☐ Email (encrypted) ☐ Pick-up in person**5 ACKNOWLEDGMENT & UNDERSTANDING** _____**I understand and acknowledge that:**

- My records may include **sensitive information** (such as HIV / sexually transmitted infection testing or other sensitive results), and I consent to the release of such information unless otherwise restricted by law.
- Once my PHI is released, it **may be re-disclosed by the recipient and may no longer be protected by HIPAA**.
- I may **revoke this authorization at any time** in writing, except to the extent that action has already been taken in reliance on it.
- I am **not required to sign** this authorization, and my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign.
- I am entitled to a copy of this signed authorization.

CUSTOM EXPIRATION DATE OR EVENT (OPTIONAL) _____

*Valid 12 months from the date signed unless revoked earlier or a different date is specified.***6 PATIENT / LEGAL REPRESENTATIVE SIGNATURE** _____

I certify that I am the patient or have legal authority to authorize the release of the patient's health information. I have read and understand this form and voluntarily authorize TruFAMED Urgent Care to release the records described above.

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE _____

DATE _____

PRINTED NAME _____

RELATIONSHIP TO PATIENT (IF NOT THE PATIENT) _____

WITNESS SIGNATURE (IF REQUIRED) _____

DATE _____

FOR CLINIC USE ONLY

REQUEST RECEIVED BY _____

DATE RECEIVED _____

DATE RECORDS RELEASED _____

RELEASED BY _____

Method of Release: ☐ Mail ☐ Fax ☐ Email ☐ In-Person Pick-Up **Pages Released:** _____☐ Identity verified before release ☐ Signed copy retained on file