ROCHESTER URGENT CARE

2701 Culver Road
Rochester, NY 14622
585-266-4000

Authorization to Release Medical Information

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____ Patient Phone Number:_____

City/State/Zip:_____ Date of Request: _____

This authorization allows Rochester Urgent Care to (check one):

☐ Send copies of your record to (or discuss information with) the provider/person/facility below.

OR

☐ Receive copies of your record from (or discuss your information with) the provider/person/facility below.

_____ _____

Name of Provider/Person/Facility Address

_____ _____ _____

City/State/Zip Phone # Fax #

Purpose for this Request (check one): ☐ Healthcare ☐ Insurance Coverage ☐ Personal

☐ Other (specify) _____

Type of Records/Information Requested (check all that apply):

☐ Urgent care visits: Date(s) _____ and/or Specific Illness/Injury_____

☐ Other (please describe): _____

I understand that:

- I may cancel this authorization at any time by submitting a **written** request to the address provided above. I understand that the cancellation will not apply to information that has already been released in response to this authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information, mental health-related care or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records ($0.75/page per paper copies, $2.00 charge per CD copy)
- Refusal to sign this authorization does not condition (affect) treatment.
- If requested, I will be given a copy of this authorization, after signing.

AUTHORIZATION VALID FOR (if nothing is checked below, this authorization is valid for this request only):

☐ This request only

☐ One year from the date of this authorization OR _____(insert date). This authorization applies to the records of the treatement received on or prior to the date of this authorization.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not patient): _____

Office Use Only: Received by Practice Administrator _____

Date request processed _____

Created 11/29/13