PRIORITY URGENT CARE

Medical Record Number:

Authorization For Use or Disclosure of Medical Record Information			
Return Completed Forms to: Priority Urgent Care 105 West Road, Ellington, CT 06029 Fax: 860-926-4245			
Patient Information			
Patient Name (*Please Print*):			Date of Birth:
Patient Address:			Phone #:
City	State:	Zip:	Email:
I hereby Authorize Urgent Care Medical Center, LLC dba Priority Urgent Care to release / obtain my health information as set forth below:			
Please choose one: **O** Release my medical record information to (below) **O** Obtain medical information from (below)			
Name/Facility:			Attention:
Address:			
Phone #.			Fax #
Purpose of Request: O Personal Request **O** Referral / Continuity of Care **O** Legal **O** Insurance **O** Other: _____			
Dates of Service: O All **O** Specific date:_____			
Specific Records to be released: Please provide the specific information as outlined below			
O Completed Health Record **O** History **O** Service and Treatment Planning **O** Lab Results **O** Other: _____			
***If any of the following information is to be included, you must check the box below, or else it will be excluded:			
O Substance Use **O** Psychiatric/Behavioral Health **O** HIV/AIDS Information			

Term and Revocation: This Authorization will remain in effect 365 days from date signed, unless a different date is indicated here: _____. I understand that I may revoke this Authorization at any time by sending a written request to Priority Urgent Care, 105 West Road, Ellington, CT 06029. The revocation will be effective immediately upon receipt of my written notice. I understand that the revocation will not have any effect on any action taken by PRIORITY URGENT CARE in reliance on this Authorization before it received my written notice of revocation.

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, or quality of treatment or payment for such treatment at PRIORITY URGENT CARE.

Potential for Redisclosure: I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure and thus, may no longer be protected by federal privacy regulations. However, if the information released is HIV/AIDS related information, psychiatric/behavioral health information, or drug and alcohol use information, Connecticut and/or federal law may prohibit the recipient from re-releasing that information.

COPY FEE: Pursuant to HIPAA and CT regulation, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies.

Signature of Patient		Date
Signature of Personal Representative	Relationship to patient:	Date

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