BayCare Urgent Care

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Patient's Legal Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____Zip: _____

Phone: _____

I authorize **BayCare Urgent Care**,

To ☐ Disclose to and/or ☐ Obtain my medical records from:

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Via: ☐ Patient Portal (Must have BayCare Patient Portal Account)

☐ Paper (Mail)

The purpose of this request: ☐ Personal ☐ Treatment (continued care) ☐ Other: _____

Please furnish the following information specified for the following visit dates: _____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated).

☐ Office Notes ☐ Laboratory Results ☐ EKG ☐ Radiology Results

☐ Complete Record ☐ Other (please describe): _____

I understand that the protected health information specified above may include mental health substance abuse (drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature: _____ Date: _____

Patient or Authorized Person: ☐ Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney

Witness: _____ Date: _____

Please return the completed authorization one of the following ways: by emailing it to BMGMedicalRecordRequest@baycare.org or returning it to your BayCare Urgent Care location.

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BAYCARE URGENT CARE RELEASE OF PROTECTED HEALTH INFORMATION

BC 7290 Rev. 02/26

PATIENT