Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to: FINI HEALTH AND WELLNESS UNITED MEDICAL Clinic of PA

To Recipient: **UNITED MEDICAL CLINIC OF PA, LLC**

Person/Company

5201 Pennell Road , Ste A

Address

Media | PA | 19063

City | State | Zip

610-497-4040 | 866-713-7699

Phone | Fax

From Clinic/Hospital: _____

Patient: _____

Patient Name | Phone | Date of Birth

(Email address)

Dates of Service (Check One and Complete Dates of Service if Required)

☑ Please provide a complete copy of my file for all dates of service

☐ Please provide a complete copy of my file for service from _____ _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

☑ All Medical Records (no films)	☑ History & Physical	
☐ Emergency Room Record	☐ Operative Report	☐ Discharge Summary
☑ Lab/Pathology Reports	☑ Radiology Reports	☐ Images (check for CD of films)
☐ Itemized Billing	☐ Other _____	

Purpose for Disclosure

☐ Disability	☐ Insurance	☐ Attorney
☐ Referring Physician	☐ Patient Request	☐ Other (please state reason)

Other _____

Please indicate your acceptance by checking the following boxes:

☑ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

☑ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

☑ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date _____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative