Authorization to Release/Obtain Medical Records

SHAKER URGENT CARE AND FAMILY PRACTICE – (Circle Address)

3846 State Route 31	308 Bessemer Road	6207 US Route 31
Donegal, PA 15628	Mt. Pleasant, PA 15666	Greensburg, PA 15601
Phone 724-593-4321-4321	724-542-4321	724-837-4321
Fax: 724-593-4328	724-542-4298	724-837-4100

I hereby authorize the disclosure of information from the health records of:

Patient's First Name	Patient's Last Name	Former or Maiden Name

Phone Number (with area code)	Email	Date of Birth	Dates of Service From:	Dates of Service To:

Health Information to disclose:

- ☐ all information
- ☐ treatment summary
- ☐ diagnoses
- ☐ immunization records
- ☐ labs & imaging studies
- ☐ dates of treatment attendance
- ☐ progress note entries - date(s): _____
- ☐ other (specify) _____

Method of disclosure:

☐ release medical records **from**:

Name: _____
Address: _____
or Fax No.: _____
_____

☐ release medical records **to**:

Milad Shaker, MD
3846 State Route 31
Donegal, PA 15628
Fax: 724-593-4328

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.

_____ _____
Signature of Patient or Parent/Guardian/Executor Date

_____
Relationship to Patient (Parent/Guardian/Executor)

Records pertaining to HIV tests or discussions or alcohol/drug treatment require separate authorizations.

Official Use Only **File with record when completed**

Completed by: _____ **Date completed:** _____ **Delivery method:** ☐ **FAXED** ☐ **MAILED** ☐ **IN PERSON** **7/2014**