MD NOW URGENT CARE

Medical Records and/or Billing Information Release Authorization Form

PATIENT INFORMATION

Last Name: _____ **First Name:** _____

Birth Date: _____ **SSN (last 4):** _____

Address 1: _____ **Phone No:** ( ) _____

City, State: _____ **Zip Code:** _____

I, the above-referenced patient, hereby acknowledge and give authorization for the release and disclosure of Medical Records and/or Billing Information, as follows:

DISCLOSE RECORDS TO / OBTAIN RECORDS FROM

Individual or Entity's Full Name: _____

Address: _____

City, State, and Zip Code: _____

Phone No: _____ ( )

Fax No: _____

Email Address: _____

REQUESTED DOCUMENTATION

Date(s) of Service: **From:** _____ **To:** _____

Information to be Disclosed:

- ☐ Physician Documents (e.g., Progress Notes, Discharge Summary Notes, Physician Orders)
- ☐ Lab/Test Results (e.g., Laboratory testing, EKG)
- ☐ Radiology/Imaging Reports
- ☐ Immunization Record(s)
- ☐ Complete Medical Record set
- ☐ Billing Records
- ☐ Other: _____

DISCLOSURE PURPOSE

Disclosure for Purpose:

- ☐ Personal Use
- ☐ Insurance/Disability
- ☐ Attorney
- ☐ Other: _____

DELIVERY FORMAT

Deliver Medical Records/ Billing Information By:

- ☐ Secure Electronic Delivery
- ☐ Mail Delivery
- ☐ Secure Facsimile Delivery

By my signature, I understand that the question of privacy between MD Now Medical Centers, Inc., my attending physician, other physician(s), other listed parties, and the patient is waived. I fully understand that my medical record or billing information maintained in connection with the date(s) of service from inception until today may contain history, diagnosis, and treatment information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws.

By my initials, I acknowledge the release of *sensitive* Protected Health Information that includes the following:

_____ Information about a mental illness or developmental disability

_____ Information about Human Immunodeficiency Virus (HIV) and/or Acquired Immunodeficiency Syndrome (AIDS) testing or treatment including the fact that an HIV test was ordered, performed, or reported, regardless of whether the test results of such tests were positive or negative

_____ Information about communicable diseases

_____ Information about venereal diseases and/or sexually transmitted infections

_____ Information about substance abuse including alcohol or drug(s)

_____ Information about Genetic testing

_____ Information about child abuse and neglect

_____ Information about abuse of an adult with a disability

_____ Information about domestic abuse/violence

_____ Information about sexual assault

_____ Information about artificial insemination

Any medical records or billing information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Once this information has been disclosed to the authorized party above, I acknowledge that it may be subject to re-disclosure by the recipient, and my privacy may no longer be protected. Only such records or information believed necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the record that are disclosed. If I refuse to sign this authorization, my medical record will not be released, except as required by law. I further understand that my records may not have been reviewed by the provider, and therefore, may not be considered as full and complete records for legal purposes. Should I require a legally verified and complete copy of my records, I will have my physician or legal representative submit a request for such records in writing, along with consent for release of Medical Records to comply with HIPAA regulations.

This authorization is valid for one year from the signed date, or until ___/___/___. I understand that I may revoke this authorization at any time (except to the extent that action has already been taken in reliance upon this authorization) by submitting revocation request to the Medical Records Department. 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.

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health and billing information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health or billing information.

Signature: _____ **Date:** _____

Print Name: _____ **Phone No.:** _____

Relationship to Patient: ☐ Self ☐ Other: _____

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Medical Records and/or Billing Information Release Authorization Form Submission Instructions

Submit completed form to the Medical Records Department utilizing 1 of the 3 methods:

1) Electronically by emailing the following addresses: MRecords@mdnow.com ; Compliance@mdnow.com

2) Mailing In hard copy format to the following address:
   MD Now Urgent Care
   2007 Palm Beach Lakes Blvd
   West Palm Beach, FL 33409

3) Sending to the following facsimile number: (866) 708-4298