Wakulla Urgent Care & Diagnostic Center

41 Feli Way
Crawfordville, FL 32327-2368
(850) 926-3140   Fax (850) 926- 3163

Authorization to **REQUEST** protected health Information to be released from another Facility:
Receiving From:

Name of Doctor or Facility____

Phone Number:________________________________   Fax:____

Address (if Known):____

Release Medical Records to: Wakulla Urgent Care & Diagnostic Center, 41 Feli Way, Crawfordville, FL 32327
(850) 926-3140   Fax (850) 926-3163

For the Purpose of: Changing PCP____   Legal Purpose______ Continuity of care_____ Other _________

Patent Name:____   D.O.B___________

Home Phone:____________________ Cell phone:___________________ Work Phone:_________________

Specific Information to be released: (Check all that apply)

General Records___   Labs/ Test Results____   Progress Notes____   Prenatal Records____

Consultations______   History & Physical____   Immunization______   Other (Specify)______

I specifically consent to release information relating to: (check all that apply)

STD___   HIV/AIDS___   Drug/Alcohol___   Mental Health___

This authorization is valid for **sixty (60) days** from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance. The revelation must be provided to Wakulla Urgent Care Medical Records Department. After **sixty (60) days** these document will be shredded if records have not been received.

I understand that I have the right to revoke this authorization in writing at any time. I understand that I must give my written revocation to Wakulla Urgent Care & Diagnostics Center. I understand the revocation will not apply to information already released in response to this authorization.

I understand that the information used or disclosed because of this form may be subject to re-disclosure by the receiving entity and may no longer be protected by the privacy regulations. I also understand that I am under no obligation to sign this authorization and my ability to obtain treatment will not depend in any way on whether I sign this authorization.

Our office protocol for medical records is to have he records sent or faxed to the receiver within 15 days. If the recorders are needed sooner than the minimum time frame, please call medical records at 850-926-3140 Ex.22 or press option 7. We will review the information and make a decision based on the urgency of need. This is not however a guarantee that we can have them ready by that date. Please note that there is a .15 cent charge per page if we are releasing the records directly to you as a patient.

Signature: ____   Date:___________________

Signature of Witness:____________________________________   Date:___________________

Office use only   Date Received: _______________________________ Received By: ______________________________

Records are to be: Faxed:___   Mailed___   Picked up by patient___