Authorization for Release of Protected Health Information

Records Mailed to Patient - $8.50/ Records Emailed to Patient - $6.50

Patient Name: _____ **DOB**: ____/____/_____

Other Names: _____

I authorize _____ to disclose/release/discuss the following information: *
(clinic name)

Check all applicable: ☐ All records ☐ Medical Records Only ☐ Billing Records Only

☐ Other (please describe): _____

***** If these records contain any information from other providers, information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I authorize the release of (check one):

☐ All dates of service ☐ Only records from ____/____/_____ to ____/____/_____

I authorize the release of the information described above to (check all applicable):

☐ Me/the patient ☐ Other person/entity name: _____

☐ Email: _____ ☐ Email: _____

☐ Fax: ** _____ ☐ Mail: Contact roi@urpt.com to arrange mailing

**Fax used for physician offices ONLY

The information may be used/disclosed for each of the following purposes (only the patient can check these boxes):

☐ At my request ☐ My healthcare ☐ Employment purposes ☐ Payment/Insurance

☐ Other _____

I understand that this authorization will remain in effect for three (3) years from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health 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 information.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Note: Records requested for the patient's sole use may be subject to an administrative fee of $8.50 for medical records mailed directly to the patient/Personal Representative with proper identification and $6.50 for medical records emailed directly to the patient/Personal Representative. All other request types are subject to the State applicable or allowable fees.

Signature of Patient or Personal Representative _____ Date _____

Print Patient Name or Personal Representative _____ Date _____

Submit form to - https://chartstream.urpt.com/, or in person at any clinic.
Questions: 1-844-319-6137