

Wakulla Urgent Care & Diagnostic Center

2615 Crawfordville Highway, Suite 103

Crawfordville, FL 32327

(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, 2615 Crawfordville Highway, #103, 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 _____

Wakulla Urgent Care & Diagnostic Center

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Crawfordville, FL 32327

(850) 926-3140 Fax (850) 926- 3163

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Wakulla Urgent Care & Diagnostic Center, 2615 Crawfordville Hwy, #103, Crawfordville, FL 32327

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Name of Doctor or Facility _____

Phone Number: _____ Fax: _____

Address (if Known): _____

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