EZCARE Walk In Medical Center

Fax # 304 916 1705

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____Date of Birth_____

I authorize the custodian of records of EZCare Walk in Medical Center to disclose/release all medical records for the above stated patient.

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

Please send the records listed above to:

Name: _____

Address: _____

_____

The authorization shall expire no later than _____and may not be valid for greater than one year 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. By signing below I authorize the use or disclosure of protected health information.

_____ _____

Signature of patient or representative Date

_____ _____

Printed name of patient or representative Relationship to patient (parent, POA ,Ect)