healthcare clinic at select Walgreens

RELEASE OF INFORMATION
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE MAIL OR FAX COMPLETED FORM TO:
Take Care Health Services
Attn: PSC – ROI Department
P.O. Box 691569, Orlando FL 32819

Phone: 855-925-4733
Fax: 888-297-8357

Medical records are kept in strict confidence and are not released without the written authorization of the patient except as permitted or required by law. I understand that Take Care Health Services providers at Healthcare Clinic at select Walgreens have 30 days to respond to this request, Take Care Health may extend this 30 day response period for another 30 days, and in certain circumstances Take Care Health may deny this request.

***Note:** This form should be used if a patient would like a third party to receive their health information on an ongoing basis or will require multiple disclosures over a designated period of time to a third party.

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Release to:

If this form is being completed by patient or guardian a copy of your PHOTO ID is required

Name/Business: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email:

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

Please indicate the time period you are requesting records for. Dates of Service From: _____ To: _____

- ☐ Entire Medical Record
- ☐ Diagnosis/Treatment notes
- ☐ Lab/X-rays
- ☐ Physical forms
- ☐ Billing Information
- ☐ Immunization records
- ☐ Referral
- ☐ Other: _____

PURPOSE OF THE USE AND DISCLOSURE

- ☐ Diagnosis & Treatment
- ☐ Insurance/Billing
- ☐ Other: _____
- ☐ Legal
- ☐ Personal

METHOD FOR RECEIVING YOUR DISCLOSURE (Check only one box below)

Paper ☐

Email ☐ In an effort to protect your health information, our standard practice is to encrypt our email. If your preference is to receive unencrypted email, please sign below. By signing below, you acknowledge that you understand an unencrypted email exposes your person and health information to additional security risks.

Signature: _____

PATIENT AGREEMENT:

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not my health plan or my health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I release the Take Care Health Services providers at select Walgreens, Take Care Health Systems, LLC, Walgreen Co., and each of their respective subsidiaries, affiliated companies, directors, officers, employers, employees, attorneys, and agents from all legal responsibility and/or liability that may arise from the release of the records I have specified.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken with reliance on it. I authorize the Take Care Health Services providers at Healthcare Clinic at select Walgreens to use or disclose of protected health information as described above.

_____ _____

Signature of Patient or Representative Date

Printed Name of Personal Representative

Relationship to the patient /representative's authority to act on behalf of the patient

EXPIRATION DATE - This Authorization will expire one (1) year from the date of your signature.