Send records to PCUC

Authorization to Release Protected Health Information

Palm Coast Urgent Care
9 Pine Cone Dr., Suite 102, Palm Coast, FL 32137
Office Ph: 386-445-6191 MEDICAL RECORDS fax # 386-445-9980

I authorize the release of Medical Records from:

Facility/Person _____ Fax# _____ Phone# _____

Address _____

City _____ State _____ Zip Code _____

Patient Name: _____ **Date of Birth:** _____

Address _____ **Phone #** _____ **SSN#** _____

City _____ **State:** _____ **Zip Code** _____

Release Medical Records to:
Palm Coast Urgent Care
9 Pine Cone Dr., Suite 102
Palm Coast, FL 32137

Please release the following information contained in my medical record regarding my care and treatment.

_____ Office Visits
_____ Labs
_____ Immunizations
_____ Radiology Reports
_____ Operative Reports
_____ OTHER

Notes: _____

_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Palm Coast Urgent Care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this **authorization will expire 6 months from execution.**
I understand this authorization extends to release of information vis U.S. mail, telephone or fax.

_____ _____
Signature of Patient or Legal Representative Date (this authorization expires after 6 months)

_____ _____
Witness Date

Fees for copying and/or reviewing records of Palm Coast Urgent Care are available upon request. Please allow sufficient time for copying of medical information (72 hour minimum processing time).