REQUEST TO OBTAIN MEDICAL RECORD INFORMATION

Physician or Facility Name: _____
Phone#: _____Fax#: _____

I hereby authorize **Redi-Med** to receive my protected health information from my medical records including HIV (AIDS) testing, STD's, and mental health and/or substance abuse services to the facility listed above.

Patient's Legal Name: _____
DOB: _____
Direct the information to: **Redi-Med Family Walk-In Clinic**
Allenscott Eacker, PA-C
Adrian Ungureanu, PA-C
4550 Executive Drive Suite 104
Naples, Fl 34119
Phone#: 239-566-1226 Fax#: 239-566-2519

PLEASE DO NOT FAX RECORDS UNLESS OTHERWISE STATED

Please release the following:

___History and Physical Exams
___Radiology Tests
___Progress Notes
___Diagnostic Test
___Physician Office Notes
___Pathology Report
___Immunizations
___Laboratory Results
___Psychiatric/Psychological
___Other

As otherwise provided by law such information may not be disclosed without a specific consent. Additionally, I have the right to refuse disclosure, I understand and acknowledge that certain information contained in my medical record require specific authorization for disclosure and except and prevent any other person from disclosing such information. Such information pertaining to treatment for mental or emotional condition, alcohol, drug abuse, or HIV testing or test results, I do hereby agree to release indemnity and hold harmless Naples Community Healthcare System, its officers, directors employees, agents and members of its staff from and against any claims against or liability by it, out of or in connection with the disclosure of medical authorized by me pursuant to this consent.

THIS CONSENT MAY BE REVOKED AT ANY TIME EXCEPT TO THE EXTENT THAT REDI-MED HAS ALREADY TAKEN ACTION IN RELIANCE ON IT. THIS CONSENT AND AUTHORIZATION SHALL AUTOMATICALLY EXPIRE 90 DAYS FROM THE DATE OF THIS CONSENT, UNLESS REVOKED BY THE PATIENT OR THE PATIENTS AUTHORIZED REPRESENTATION PRIOR TO THAT TIME.

Patients Signature: _____
Date: _____
If legal representative, sign below and state relationship and authority to do so.
Legal Representative: _____
Date: _____
Authority/Relationship to patient: _____