My Way Medical
DIRECT PRIMARY CARE

Patient's Name: _____

Date of Birth: _____

I request and authorize (please list the name of any physicians, outpatient testing centers, and/or hospitals where you have received care):

_____

_____

to release healthcare information, for the purpose of continuing medical care, of the patient named above to:

Samuel Urick III, D.O.
150 Pleasant Drive, Suite 102
Aliquippa, PA 15001
Phone: 724-257-2157
Fax 724-257-2158

This request and authorization applies to:

☐ All healthcare information OR

☐ Healthcare information related to the following treatment, condition, or dates:

_____

Any HIV, Substance Abuse, and/or Mental Health information contained in the parts of the records will be released through this authorization unless otherwise indicated.

Do not release: ☐ Drug/Alcohol ☐ HIV ☐ Mental Health

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified. I understand that I have the right to revoke this authorization at any time by sending a written request to Dr. Urick.

Patient Signature: _____ Date Signed: _____

A minor may authorize release of Drug and Alcohol treatment information.

A minor 14 years of age or older may authorize the release of inpatient mental health information.

OR

Signature of Authorized Representative: _____

Relationship to Patient: _____ Date Signed: _____

Patient Rights and Responsibilities

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for the reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

A disclosure statement, as required by law, will accompany all records released.

Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released. Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) Dr. Urick and any employees of My Way Medical Direct Primary Care have no responsibility or liability as a result of redisclosure and (2) such information would no longer be protected by the Privacy Rule.

My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization

My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.

Dr. Urick cannot require me to sign the Authorization in order to receive treatment.

In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment 2) The prognosis of the client 3) The nature of the program 4) A brief description of the progress of the client 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
I am entitled to a copy of this completed Authorization form.