Bear
121 Becks Woods Dr.
Suite 100
Bear, DE 19701
Fax (302) 836-4302

Dover
1113 S. State Street
Suite #202
Dover, DE 19901
Fax (302) 836-4302

Smyrna
38 Deak Drive
Smyrna, DE 19977
Fax (302) 653-9563

Wilmington
1021 Gilpin Ave.
Suite 203
Wilmington, DE 19806
Fax (302) 836-4302

Patient Name: _____

Date of Birth: _____ Phone #: _____

Please be advised that all of the below needs to be filled out in order to process your paperwork correctly.

Last time you were seen for this condition:

Date your paperwork is due: _____/_____/_____ **Name of provider to fill out this paperwork:**

(TO BE COMPLETED BY STAFF)	Date received by office: _____/_____/_____

***** PLEASE BE ADVISED:** THERE IS A $**15.00 FEE** FOR PAPERWORK.
THE TURN AROUND TIME FOR PAPERWORK TO BE COMPLETED BY PROVIDER IS 3 – 10 BUSINESS DAYS.
IF AN APPOINTMENT IS NEEDED PLEASE MAKE SURE THE CORRECT CONTACT NUMBER IS PROVIDED. ***

FROM:	**United Medical Clinic, LLC** **Tel No. (866) 862-2955**	**TO:** Name of Entity:

INFORMATION TO BE RELEASED

Name of Paperwork: _____

METHOD OF DISCLOSURE	
Pick Up (Name of Individual who will pick up paperwork): _____	□ Fax #: _____ □ Mail to: _____ _____

Patient Acknowledgement:

By signing below, I certify that:I understand that I may inspect a copy of the records being disclosed

- I understand that unless excluded and noted herein the information being disclosed may contain sensitive information such as, but not limited to: sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, physical abuse, or treatment for drug and alcohol abuse and psychotherapy notes.
- I understand that this authorization will expire in 3 months following the date of this authorization.
- I understand that I may revoke this authorization at any time (except to the extent that the information was already disclosed on reliance of this signed authorization) by notifying the provider's office in writing.
- I understand that if the person or organization that receives information is not covered by privacy regulations, the information may be disclosed and would no longer be protected.
- I understand that I have the right to receive a copy of this form.
- I understand that photo ID is required if the paperwork is being picked up by another individual
- United Medical Clinic of DE, LLC from all legal responsibility and/or liability that may arise from the release of the records I have specified.

I authorize the release of all information indicated. I release _____ DATE

PATIENT NAME: _____

X _____ _____

PATIENT/PARENT/GUARDIAN/CAREGIVER SIGNATURE RELATIONSHIP TO PATIENT