PREMIER URGENT CARE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: _____ Phone Number: _____

Social Security Number: _____ Date of Birth _____

Address: _____

City: _____ State: _____ Zip Code: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

☐ Release to: _____

☐ Release to: _____
(Name of medical facility, physician, etc.)

_____
(Street Address)

_____
(City, State, Zip code)

2. The type and amount of information to be used or disclosed is as follows: **(include dates where appropriate)**
   - ☐ Complete Records
   - ☐ History and Physical Exams
   - ☐ X-Ray, Lab, EKG Reports
   - ☐ Pathology Reports
   - ☐ Developmental Disabilities
   - ☐ Mental Health
   - ☐ Other, specify: _____

3. I understand I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the health information management department.

_____
Signature of Patient or Legal Representative Date

_____
Signed by Legal Representative, Relationship to Patient Signature of Witness