



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(PLEASE PRINT LEGIBLY)

PLEASE NOTE: There is a \$25.00 per person charge for records not sent directly to a medical provider for medical use . Please pre-pay by check or credit card.

I hereby authorize the use or disclosure of my Protected Health Information (PHI) including (circle all that apply): office notes / x-ray reports / laboratory reports for the inclusive dates beginning _____ and ending _____.

PATIENT INFORMATION:

Patient Name: _____ DOB: ____/____/____
SSN: ____/____/____ Medical Record Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

TO BE SENT VIA US MAIL/FAX TO:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization. I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to Urgent Care Express. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

EXPIRATION. This Authorization automatically expires one year from the date signed, unless a different date is provided. [Insert date or event]: _____

SIGNATURE

Signature: _____
Printed Name: _____

Date: ____/____/____
If signing on behalf of patient, state relationship _____

Witness: _____
Printed Name: _____