URGENT MEDICAL CENTER

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____, hereafter referred to as the Patient, hereby authorize the release and disclosure of my health record including billing information:

Patient Name	**Date of Birth**	**Social Security Number**
Patient Address		

Date of Service Range: From: _____/_____/_____ To: _____/_____/_____		
Please check where the information will be going to/from: ☐ To ☐ From: Name: _____		
Street Address:		
City, State, Zip:		
Phone #:	Fax #:	Confidential Email:

I fully understand that:

1. My health record and/or billing information maintained in connection with the date(s) of service mentioned above may contain mental health, alcohol and drug abuse history, Human Immunodeficiency Virus (HIV) test results, or Acquired Immunodeficiency Syndrome (AIDS) information.
2. Once this information has been disclosed to the authorized party above, it may be subject to re-disclosure by the authorized party and my privacy may no longer be protected. I may inspect and/or arrange for photocopies of the record that is being disclosed.
3. After the custodian of records discloses my health information, it may no longer be protected by federal privacy laws.
4. My records may not have been reviewed by the provider and therefore may not be considered as full and complete for legal purposes.
5. This authorization is good for one year from date signed and that I may revoke this authorization by submitting a revocation request to Urgent Medical Center Management department.

By signing below I authorize the release of my health record as stated above.

Patient Signature: _____ Date: _____