AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

AFFORDABLE URGENT MEDICAL CARE
900 E COMMERCE ST., HERNANDO, MS 38632
PHONE 662-429-9111 · FAX 662-429-6111

Date _____

Patient Name _____ D.O.B. _____

I HERBY AUTHORIZE AND REQUEST THAT ALL MEDICAL INFORMATION FROM:

_____

_____

TO BE RELEASED TO PROVIDERS OF AFFORDABLE URGENT MEDICAL CARE AT TH ABOVE ADDRESS.

Please include all office notes with any test results, etc.

Purpose of this release is:

____ Changing physicians

____ Moving

____ Litigations

____ Insurance Claims

____ Other: _____

I understand I may revoke this consent to release information at anytime. I also understand that my release shall not constitute a breach of my right to confidentiality. The authorization expires 60 days from the above date, and it covers only treatment prior to that date.

Print name of patient _____

Relationship to patient _____

Home Telephone No. _____ Cell Phone No. _____

Signature of patient or guardian _____

NOTICE to person or agency receiving information: Federal law and regulations prohibit furth disclosure of the information whose confidentiality is protected in the absence of a specific consent of the patient or person authorized to consent for the patient.