Authorization for Release of Medical Records

DUKE CITY URGENT CARE

***This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. PLEASE REVIEW CAREFULLY.**

Patient Name: _____ Date of Birth: ___/___/___

Do we have your permission to:

Send lab results to your home? Y or N

Do we have your permission to leave the following on your email, home answering machine, and/or mobile phone's voicemail:

Billing information? Y or N

Medical information (ie: lab results, etc.)? Y or N

I give permission to share appointment, billing, and medical information with the person(s) named below:

Name: _____ Relationship_____

Name: _____ Relationship_____

I authorize Duke City Urgent Care to send or obtain my medical records to/from the following physicians below:

1._____ 4._____

2._____ 5._____

3._____ 6._____

- I understand that my medical records may contain information about but not limited to: alcohol and/or drug treatment, mental health or psychiatric, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need indicated above.
- I understand that if I choose to add anyone else to this list, I must sign another release form and that our office will not add any additional persons to this form.
- I understand that in case of an emergency, my records will be sent out to the appropriate caregivers even though they may not be listed on this form.
- I understand that certain records may be sent via fax and I relieve Duke City Urgent Care and employee of any liability from mis-transmission by telefax.
- A photocopy of this authorization shall have the same effects as the original.
- This medical release will expire a year from the date of signature.

_____ _____

Patient Signature Date

_____ _____ _____

Parent/Guardian Signature (If minor) Relationship to minor Date