TOTAL ACCESS URGENT CARE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Phone Number _____

Social Security Number _____ Date of Birth: _____

Address: _____

City _____ State: _____ Zip: _____

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

   Receive from: _____
   (Name of medical facility, physician, etc.)
   _____
   (Street Address)
   _____
   (City/State/Zip)

2. The type and amount of information to be used or disclosed is as follows: **(include dates where appropriate)**
   Complete records
   Pre-employment/Company Name _____
   Work Comp/Company Name _____

History & physical exams	Substance abuse	Developmental disabilities
X-ray, lab & EKG reports	Pathology reports	Mental health
HIV test		

   Other, specify: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present by written revocation to the health information management department. 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 with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

5. 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

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

Note: *You may fax this request to (314) 373-5757. Record requests take an average of 7 to 10 working days to process.*