TOTAL ACCESS URGENT CARE

# WRITTEN 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.

6. This section must be used, in the event that a patient is unable to request his / her own medical records. This section applies to requests from Hospitals, Physician's office, or other qualified health professional, acting in the best interest of the patient. Note: This section may only be used, IF the patient is unable to legally request his / her record.

Name of Hospital or Physician's Office _____

Name and Title of Requestor _____

Address _____

Phone & Fax Numbers _____

_____ _____

Signature of Patient, Legal Representative, or Health Care Requestor Date

_____ _____

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

***Note: Please fax this request to 314-270-3694.***