Family First
URGENT CARE
WE CARE FOR YOU LIKE FAMILY

PATIENT INFORMATION	
Last Name/ First Name:	DOB:

HIPAA – AUTHORIZATION TO RELASE PROTECTED HEALTH INFORMATION

I give my authorization to release my protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities. I understand that Family First Urgent Care may leave voice mail, send electronic correspondence or fax results pertaining to appointment information, financial information and/or treatment plans. I understand that I may withdrawal my consent at any time and will submit my request in writing to Family First Urgent Care privacy officer.

FOR MINORS ONLY: I _____(parent name), being the parent of the above listed patient give my authorization to release my child's protected health information including results of my laboratory test, X-ray and/or any test and treatment plans to the listed designated individuals/entities who are authorized to bring my child to his/her appointments.

Patient Initials

	My Spouse (Name):	**Phone No.:**
	My Child (Name):	**Phone No.:**
	Other (Name):	**Phone No.:**
	Personal Representative (Name):	**Phone No.:**
	May be left on my voice mail or answering machine at home	**Phone No.:**
	May be left on my cell phone	**Phone No.:**
	MAY NOT BE GIVEN TO ANYONE ELSE OTHER THAN MYSELF	

This authorization for release of information covers the period of healthcare for one year from my signature below. I authorize Family First Urgent Care, its providers, affiliates and/or associates to use this information for continuity of care, medical treatment, consultation, billing or claims payment, or other purposes as needed.

I ACKNOWLEGE I HAVE BEEN INFORMED OF FAMILY FIRST URGENT CARE OPERATING PROCEDURES. MY SIGNATURE AUTHORIZES MY PERMISSION TO CONTINUE CARE WITH FAMILY FIRST URGENT CARE, ITS PROVIDERS, AFFILIATES AND/OR ASSOCIATES.

Signature: _____ Date: _____

Witness: _____ Date: _____