Family First
URGENT CARE
WE CARE FOR YOU LIKE FAMILY

PATIENT INFORMATION

Last name:	First Name:
DOB:	Social Security #:

AUTHORIZATION TO RELEASE INFORMATION

☐ I hereby authorize the use or disclosure of protected health information for the purpose of:

☐ Continuity of Care
☐ Insurance Request
☐ Treatment
☐ At the request of the patient (self)
☐ Legal Investigation/Action
☐ Other_____

To:	Address/City/State:
Phone:	Fax:

Information to be disclosed (unless indicated only one year treatment notes will be sent):

☐ Entire Medical Record
☐ Billing Records
☐ Radiology film or images
☐ Progress/Treatment Notes
☐ Laboratory Records
☐ Other: _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

☐ I hereby authorize the use or disclosure of protected health information for the purpose of continuity of care and treatment to: **Family First Urgent Care, 2510 S. Loop 336 West, Suite 115 Conroe, Texas 77304**

☐ **Kimberly Byrum, NP**
☐ **Connie Bowlin, NP**
☐ **Claire Pollard, NP**
☐ _____

Information to be disclosed:

☐ Entire Medical Record
☐ Billing Records
☐ Radiology film or images
☐ Progress/Treatment Notes
☐ Laboratory Records
☐ Other:_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I am giving authorization to use, disclose, or exchange my health information. I understand that I may be charged a fee for record copies. I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the privacy officer in writing. I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and may not be protected by federal privacy regulations. I understand that this authorization will expire one year from listed date unless I submit in writing to the privacy officer.

Signature:	Date:
Witness/Title:	Date: