Family First
URGENT CARE
WE CARE FOR YOU LIKE FAMILY

PATIENT INFORMATION

Patient 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.

My Spouse (Name):	**Phone No.:**
My Child (Name):	**Phone No.:**
Personal Representative (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**
Other (Name):	**Phone No.:**

Additional Instruction:

☐ I **DO NOT** wish to give anyone else permission to access my health information.

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. (IF THE PATIENT IS A MINOR, THE PARENT/GUARDIAN FILLING THIS FORM GIVES AUTHORIZATION TO RELEASE THE 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.)

Signature: _____ Date: _____

Witness: _____ Date: _____

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