2400 W. Sample Road, Suite 4 Pompano Beach, FL 33073 Phone 954-580-1036/Fax 954-580-1099

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____(**Patient's Name**), _____(**Date of Birth**) do hereby authorize the release and disclosure of medical records and information **from** Premier Urgent Care Center.
TO

Institution, Individual or Agency	
Street Address	
City, State, Zip	
Phone #	Fax #

I hereby waive my right to privacy between the facility, my attending physician, or other physician(s) and myself. I fully understand that my medical record or information maintained in connection with the date(s) of service may contain information regarding mental health, alcohol and drug abuse history, Human Immunodeficiency Virus (HIV) test result or Acquired Immunodeficiency Syndrome (AIDS) information. The medical records or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Once this information has been disclosed to the authorized party above, I acknowledge that it may be subject to re-disclosure by the recipient and my privacy may no longer be protected. Only records or information deemed necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the records that are disclosed at a cost of $1.00 per page. If I refuse to sign this authorization, my medical record will not be released.

Information requested_____
(specify type of information)

Purpose of the Request:
This authorization is valid for one year from the date signed or until_____. I may revoke this authorization at anytime by submitting a written revocation request to the Health Information Management department at Premier Urgent Care Center.

Patient/Parental Signature_____ Date_____

Patient/Parental Printed Name_____

Relationship to Patient_____
Phone #_____