AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your physician or the staff of 1st Class Urgent Care to give copies of and/or discuss your condition /exams /procedures / x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization for doing so.

In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition the law stipulates that these rules may be waived.

I authorize 1st Class Urgent Care to release any and all information (including verbal information, copies of x-rays and medical records) concerning my medical care to the following individual(s):

Name_____Relationship_____Phone #_____

_____I DO NOT authorize 1st Class Urgent Care to release my information concerning my care to any individual.

_____I authorize 1st Class Urgent Care to leave a detailed message on the following authorized phone number: _____

_____I DO NOT authorize 1st Class Urgent Care to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option that I, the patient assume full responsibility for contacting 1st Class Urgent Care for the results of all testing.

Print Patient Name_____

Signature of Patient or Parent/Guardian_____Date_____

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with the federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, we must obtain authorization to discuss financial information with members of your family or other individuals that you designate.

I authorize 1st Class Urgent Care to verbally discuss my financial information with the following individual(s):

Name_____Relationship_____Phone #_____

Print Patient Name_____

Signature of Patient or Parent/Guardian_____Date_____

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how 1st Class Urgent Care may use or disclose my protected health information. I understand that 1st Class Urgent Care reserves the right to change the privacy notice, and that a copy of the revised notice will be made available to me.

Signature_____Date_____