Greater Mobile Urgent Care, P.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
FROM OTHER PROVIDER TO GREATER MOBILE URGENT CARE

I, ____, HEREBY AUTHORIZE GREATER MOBILE URGENT CARE:

CIRCLE ONE & FAX TO # BELOW

2350 SCHILLINGER RD MOBILE, AL 36695 FAX# 251.410.6127	7943 MOFFETT RD SEMMES, AL 36575 FAX# 251.445-3718	4402 OLD SHELL RD MOBILE, AL 36608 FAX# 251.445.3719

TO RELEASE MY RECORDS TO:

____

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The Specific Information To Be Disclosed Includes:

[ ] PHYSICIAN'S CHART NOTES [ ] X-RAY REPORTS [ ] ALL RECORDS & REPORTS
[ ] ANCILLARY REPORTS [ ] FINANCIAL REPORTS [ ] OTHER_______________

INFORMATION WHICH MAY NOT BE DISCLOSED:

____

DATES OF SERVICE TO BE INCLUDED, FROM: ____________ TO: ____________ [ ] ALL DATES OF SERVICE

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

PATIENT NAME______________________________ SSN#_______________

DATE OF BIRTH_____ /_____ / _____

ADDRESS_________________________ CITY____________ STATE____ ZIP__________

CONTACT # ________________________________

AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR PATIENT'S LEGAL REPRESENTATIVE:

______________________________ ______________________
(SIGNATURE OF PATIENT) (DATE)

____________________________________ ______________________
(SIGNATURE OF AUTHORIZED REPRESENTATIVE) (DATE)