HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Complete appropriate information regarding the release of personal medical information in the spaces below:

PROVIDER Institution/location of information to be released	☐ STOCKTON URGENT CARE 1148 W. HAMMER LANE STOCKTON CA 95209 (209) 952-9696 ☐ _____
REQUESTOR To whom the information will be released	☐ Medical Provider _____ ☐ Family Members _____ ☐ Other _____
INFORMATION SHOULD INCLUDE:	☐Evaluation Forms ☐Operative Reports ☐Imaging & Reports ☐All medical Records ☐Treatment Plans ☐Billing Records ☐Lab Data, Including: _____ ☐OTHER: _____
INFORMATION LIMITATIONS (IF ANY)	*List any restrictions on information to be released:*
PURPOSE OF INFORMATION RELEASE	

I give permission to the PROVIDER to release Medical Record Information to the REQUESTOR. The information released will be restricted by any INFORMATION LIMITATIONS outlined above.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and/or drug abuse. I authorize the release or disclosure of this type of information.

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until revoked in writing.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative

_____ _____

Witness Signature Date