AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations:

   Patient Name _____ Date of Birth _____

   Address _____ Telephone _____
   _____ Patient No. _____

   Covering the period(s) of health care:
   From (date) _____ To (date) _____ and

2. Information to be disclosed (check as appropriate):

   _____ Complete health record(s)

   ONLY:
   ____ Healthcare Information relating to the following treatment, condition, or dates:
   _____

   ____ Other: _____

3. _____ (Initials) I specifically consent to the release of any information related to testing and treatment for STD(s), HIV, AIDS, mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records. THIS PROVISION MUST BE INITIALED BY PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

4. This information is to be disclosed to (name & address)
   _____
   _____
   _____

   Information disclosed by (name & address)
   Neighborhood Urgent Care
   P.O. Box 787
   Jacksboro, TN 37757

   for the purpose(s) of _____, or
   □ At the request of the individual

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire Ninety (90) days from the date signed below.

6. I understand that I have the right to refuse to sign this form and that my refusal will not result in the provider conditioning the provision of Healthcare with two exceptions: **1**. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the provider declining to provide the research-related treatment. **2.** Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the provider declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

   Signed: _____ _____

   Patient Date