Authorization for Release of Health Information

Patient Name:_____ Date of Birth:_____
SSN:_____

Address:_____ City:_____ State:_____
Zip:_____

Home Phone:_____ Cell Phone:_____

The following individual/organization is authorized to release requested health information:

Name:_____ Relationship to
Patient:_____

Address:_____ City:_____ State:_____
Zip:_____

Phone:_____ Fax:_____

Requested health information to be released:

☐ All Records ☐ Office Notes ☐ Laboratory/Pathology Records ☐ Radiology Records

☐ Immunization Records ☐ Medication Records ☐ Billing Information

☐ Other:_____

This information may be released to and used by the following organization:

Port City Urgent Care & Family Practice 706 South College Rd Wilmington, NC 28403

Phone: 910-798-2212 Fax: 910-920-9905

Patient's Right and Signature: I understand that I have a right to revoke this authorization at any time by notifying the medical records department of the above named organization/individual in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization. I understand that I may request to obtain a copy of the information to be used or disclosed per Port City Urgent Care & Family Practice notice of privacy practices policy. This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.

_____ _____

Signature of Patient (patient's personal representative) Date

_____ _____

Printed Name of Patient Representative Relationship to Patient

☐ ID Verified ☐ Signature Verified Staff Initials:_____