# Authorization for Release of Health Information

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

Address:_____ City:_____
State:_____Zip:_____

Phone:_____ Cell Phone:_____

**Port City Urgent Care & Family Practice** located at 706 South College Rd in Wilmington, NC is authorized to release the following requested health information.

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

☐ Immunization Records ☐ Medication Records ☐ Billing Information ☐
Other:_____

**This Information may to be released to and used by the following individual/organization:**

Name:_____ Relationship to
Patient:_____

Address:_____ City:_____
State:_____Zip:_____

Phone:_____ Fax:_____

**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 (patients personal representative) Date

_____ _____

Printed Name of Patient Representative Relationship to Patient

☐ ID Verified ☐ Signature Verified Staff Initials:_____