MEDNOW
Urgent Care + Walk-in Center

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize MedNow Urgent Care Center to disclose my individually identifiable health information as described below, which may included information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any such related information. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity, such as an insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name _____ _____ _____
First Middle Last

Date of Birth: _____ Social Security Number _____

Description of information to be released: ☐ 2 Years ☐ 5 Years ☐ All ☐ Billing ☐ Other

Description of the purpose of the use and/or disclosure: _____

_____

The health information described herein shall be released to: (check the appropriate caterogy)

☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other

Name where records are being sent: _____

_____ _____ _____ _____
Address City State Zip Code

I further understand that I may revoke this authorization at any time by notifying MedNow Urgent Care Center in writing at 104 North Bel Air Rd., Suite 101, Evans, GA 30809. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions before receipt of the written revocation.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until (date) _____.

_____ _____
Signature of Patient of Patient's Representative Date

_____ _____
Printed Name of Patient of Patient's Representative Relationship to Patient

_____
Legal Authority (attach supporting document)