

**BULVERDE URGENT CARE AUTHORIZATION FOR THE RELEASE OF  
PROTECTED HEALTH INFORMATION**

PATIENT NAME \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the following individual or organization  
\_\_\_\_\_, to disclose my protected  
health information (PHI) as described in more detail in the checked items below to:

**BULVERDE URGENT CARE  
19750 HWY 46, STE. 104  
SPRING BRANCH, TX 78070**

I specifically authorize the use and disclosure of the following PHI for the purpose of complete continued medical care:

<input type="checkbox"/> History/Physical	<input type="checkbox"/> Consultation reports
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Laboratory/Radiological/Diagnostic Test Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative reports
<input type="checkbox"/> Other _____	<input type="checkbox"/> All Medical Records

\*\*\*\*\*NOTE: This PHI is being used or disclosed to carry out treatment and continued medical care of the above patient or for the following purpose: \_\_\_\_\_

**I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.**

YES, I consent to the release of this information.  NO, I do not consent to the release of this information.

This authorization shall be in force and effect until \_\_\_\_\_ or one year from the date signed below, at which time this authorization to use or disclose this health information expires.

**I understand and agree that:**

- \*I have the right to revoke this authorization, in writing, at any time by sending such written notice to the Office Manager. A revocation is not effective except to the extent that Bulverde Urgent Care has relied on the use of the disclosure of the protected health information.
- \*Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- \*Bulverde Urgent Care will not condition treatment, payment, and enrollment in a health plan or eligibility of benefits on whether I provide authorization for the requested use or disclosure.
- \*I have the right to refuse to sign this authorization form.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

SIGNATURE WITNESSED BY \_\_\_\_\_

**TO THE OFFICE STAFF OF THE ENTITY RELEASING RECORDS: Please do not fax records over 10 pages to Bulverde Urgent Care. Mail records to above address.**