BOERNE 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:

BOERNE URGENT CARE
1201 S. MAIN ST., STE. 118
SPRING BRANCH, TX 78006

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

___History/Physical ___Consultation reports
___Pathology Reports ___Laboratory/Radiological/Diagnostic Test Reports
___Discharge Summary ___Operative reports
___Other____________ ___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 Boerne 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.
*Boerne 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 Boerne Urgent Care. Mail records to above address.