Authorization For Release of Medical Information

Please Print Clearly

Patient's Full Name	Date of Birth (Month/Day/Year)
Street Address	Social Security #
City, State, Zip	Home Telephone

At the request of the Individual, I ______________________________ do hereby authorize Urgent Specialty Associates to release:

Patient Name

Dates of ____

□ ALL □ Discharge Summary □ History & Physical □ Progress Notes □ Operative Notes

□ Pathology Reports □ Lab Reports □ Radiology Reports □ Emergency Reports

□ Other ____

□ I DO □ I DO NOT Authorize the release of information related to AIDS or HIV infection, psychiatric care, and/or psychological assessment, and treatment for alcohol and/or drug use.

Information Release to: ____

Name of Company/Agency/Facility/Person

____

Street Address City, State, Zip

Purpose of Disclosure:

□ Referral to Specialist □ Insurance □ Workers' Comp □ Physician Change □ Legal Investigation

□ Disability Determination □ Personal □ Continuing Care

I hereby authorize disclosure of health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not effect any information released prior to the notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and it would then no longer be protected by federal regulations. I understand that Urgent Specialty Assoicates will not condition its treatment of me on whether or not I sign this Authorization.

____ ____________________

Signature of Individual or Guardian or Person Representative of Patient's Estate Date