STATESBORO URGENT CARE

Statesboro Urgent Care

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Statesboro Urgent Care to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Statesboro Urgent Care to use or disclose to

_____ the following individually identifiable health information
Person or Entity to Receive the information

specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

_____

This authorization will expire on _____.
{Expiration Date or Defined Event}.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that DocNow Urgent Care, PC has acted in reliance upon this authorization. My written revocation must be submitted to Statesboro Urgent Care 1701 ABC Street, Anywhere, US 48XXX.

Signed by:_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Witness