Brazos Valley Urgent Care

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Phone: 979-764-2882
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize **Brazos Valley Urgent Care** to ☐ RELEASE TO: ☐ RECEIVE FROM:

Person or Organization: ____

Address: ___________________________________ Phone: ______________________

Fax (if applicable): ______________________

Information/copies from the medical records on:

Patient: _________________________________ Date of Birth: _____/_____/__________

Social Security: _________________________ Date of Service: _____/_____/__________

INFORMATION TO BE RELEASED: (Please check)
☐ Entire Record ☐ Radiology Reports ☐ Lab ☐ Pathology Reports ☐ Billing
☐ Immunization Reports ☐ HIV Test Results ☐ AIDS Information ☐ History and Physical
☐ Other __________________________________

This information is being released for the following purpose: (Please check)
☐ Continued Care ☐ Attorney/Litigation ☐ Insurance ☐ Disability Services
☐ Other __________________________________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here: ________________________.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits from making any further disclosure of it without specific written consent of the person to whom it pertains, other information is not sufficient for this purpose.
FOR PATIENT'S RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

____ _____/_____/__________
Signature of Patient or Legally Authorized Representative Date

____
Relationship to Patient

____ _____/_____/__________
Witness: Signature/Printed Name Date