AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare providers(s) named below to release confidential medical information and records. **Note**: *Information and records regarding treatment if minors, HVI, psychiatric/ mental health conditions, or alcohol/ substance abuse have special rules that require specific Authorization.*

AUTHORIZATION

I hereby authorize:_____
Physician/ Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail. Fax or other electronic methods.

TO:

URGENT CARE & TELEHEALTH
1387 E 2ND STREET
BENICIA, CA 94510
P:707.377.1005 F:833.992.2353

The medical information/records will be used for the following purpose:_____
This authorization is:

- ❏ Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)
- ❏ Limited to the following medical information:_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse: _____(Initial) Test for Antibodies to HIV: _____(Initial)
Psychiatric/ Mental Health: : _____(Initial) HIV Diagnosis/ Treatment: _____(Initial)
Duration: This authorization shall be effective immediately and remain in effect until _____

Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative Relationship if other than patient

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness Name Witness Signature