Temecula
24 Hour Urgent Care
"We're here when you need us"
41715 Winchester Rd., Ste. 101
Temecula, CA 92590
Ph: 951.308.4451
Fax: 951.506.0992

Carlsbad
Urgent Care
"We're here when you need us"
2804 Roosevelt Street
Carlsbad, CA 92008
Ph: 760.720.2804
Fax: 760.720.7400

Authorization to Release Medical Information Form

Patient's name: _____ Phone: (_____) _____Date Of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Release To:

Name: _____ Phone: (_____) _____Fax_____: _____

Address: _____ City: _____ State: _____ Zip: _____

Release From:

Name: _____ Phone: (_____) _____Fax_____: _____

Address: _____ City: _____ State: _____ Zip: _____

The purpose of this disclosure is: ☐ At the request of the Individual ☐ Referral for Medical treatment

The dates of patient care covered by this authorization form are: From: _____ to: _____

Release the Following Information

☐ Discharge Summary ☐ Pathology Report(s) ☐ Emergency Record(s) ☐ History & Physical
☐ Radiology Report(s) ☐ Consultation(s) ☐ Lab Report(s) ☐ Treatment Plan(s)
☐ Operative Report(s) ☐ Cardiology Report(s) ☐ Progress Notes
☐ Other Records as Specified _____
☐ Entire Medical Record (Except for Records Concerning Highly Confidential Information).

Release of Highly Confidential Information:

By checking any of the boxes next the category of highly confidential Information listed below, I specifically authorize the use and or disclosure of the category of Highly Confidential Information indicated next to the box. Please check all that apply-Leaving a box unchecked may result in no information being disclosed for any purpose.

☐ Mental Illness / Developmental Disability ☐ Sexually Transmitted Disease (STD's)
☐ HIV / AIDS Testing or Treatment ☐ Substance Abuse (i.e. Alcohol or Drugs)

This Authorization Will Remain in Effect:

☐ From the date of this authorization until: _____ (May not exceed One year).
☐ Until the releasing entity fulfills the request, or 120 days from the date this Authorization is signed, whichever comes first.

I understand that:

I have the right to revoke this Authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity in reliance on this Authorization before it received my written notice of revocation. I may contact Temecula 24 Hour Urgent Care / Carlsbad Urgent Care, Management with any questions or concerns pertaining to this Authorization.

If signed by Legal Representative, relationship to Patient: _____

HIPAA AUTHORZATION TO USE AND DISCLOSE HEALTH INFORMATION

I have read and understand the terms and authorization, and hereby knowingly and voluntarily authorize above Releasing Entity to use and disclose my health information in the manner described above.

_____ _____
Signature of patient or Legal Representation Date / Time

_____ _____
Signature of Witness Date / Time