Swift Health Urgent Care

Authorization to Release Information

Name _____ **EHR#** _____

_____ _____ _____ _____

Address City State Zip Code

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)*

☐ **use the following protected health information, and/or** ☐ **disclose the following protected health or other information to:**

Name and Address of health provider or entity to release this information: _____

_____

Name and Address of person (s) or category of person to whom this information will be sent: _____

_____

Specific information to be released:

☐ **Medical Records** ☐ **Lab Results** ☐ **Alcohol Drug Abuse**

☐ **Treatment Records** ☐ **Complete History** ☐ **Communicable Disease HIV/AIDS**

☐ **Diagnostic Records**

☐ **Other:** _____

This protected health or other information is being used or disclosed for the following purposes:

_____

_____

I understand that my authorization will remain in effect from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable federal, state and city laws.

Terms for Termination/Revocation: You have the right to revoke the authorization at any time. However, your revocation will not affect any use or disclosure that we made in reliance upon your authorization before we learn of your revocation. You may revoke the authorization by writing to Swift Health Urgent Care 5185 Old National Highway Atlanta GA 30349

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

I authorize release of the above-specified information.

_____ _____

Printed Name of Participant or Personal Representative **Signature of Participant or Personal Representative**

_____

Date

If the person signing the form is not the individual whose information is being disclosed, please indicate your relationship to that person:

☐ **Parent or legal guardian of a child under the age of 18.**

☐ **Personal Representative (please attach documentation, ie. Power of Attorney, Court Order, Health Care Proxy).**