CareWell URGENT CARE CLEARCHOICEMD URGENT CARE

Authorization for Disclosure of Health Care Information

Patient Name:_____ **Date of Birth**:_____

Address:_____

Email Address:_____

I hereby authorize CareWell/ClearChoiceMD Urgent Care to disclose my protected health information from my health record as indicated below. I understand that authorizing the use or disclosure of the information identified below is voluntary. I need not sign this form to ensure healthcare treatment.

Please complete all sections of this form. *If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.*

Information to be released for dates of service: **Start**:_____ **End**:_____

[ ] Occupational Health Services authorized by your employer [ ] Workers Compensation Medical Form

[ ] Results of Physical Examination

[ ] Medical Record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions

Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

_____I specifically give permission to share information in my record about HIV testing.

____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

Release Information to:

PCP: _____ Phone: _____ Fax: _____

Employer: _____ Phone: _____ Fax: _____

Health Insurance Plan: _____ Phone: _____ Fax: _____

Other: _____ Phone: _____ Fax: _____

Purpose of Disclosure: [ ] Own Records [ ] Insurance Claim [ ] Employment Purposes [ ] PCP [ ] Other

I understand that this authorization can be revoked in writing at any time. Written revocation must be delivered to CareWell/ClearChoiceMD Urgent Care. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released. This authorization shall be valid for 1 year unless otherwise specified.
*I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting its confidentiality.

_____ _____

Signature of Patient or Guardian/Patient Representative **Date**

_____ _____

Print Guardian or Patient Representative Name **Relationship to Patient**