HIPAA AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Please Print:

Patient Name: _____

Date of Birth: _____ Social Security Number : _____

I, the undersigned, authorize and request PICKENS URGENT CARE, LLC d/b/a PICKENS URGENT CARE, LLC to release a copy of the Patient's entire medical record to the following Recipient for the purpose of the Patient's treatment:

Recipient: PICKENS URGENT CARE, LLC. 744 Noah Drive, Suite 108-109. 30143, Jasper Georgia. Fax: 706 692 0280. Email: info@pickenscare.com

I understand that the health information to be released includes any and all inpatient admission records, ER visit records, outpatient clinic notes, diagnostic testing reports, films, consults, doctor's orders, progress notes, nurse's notes, laboratory testing results, reports, correspondence, consultations, memoranda, treatment plans, discharge summaries, medical summaries, examination records, history and physicals, diagnoses, consents and/or any writing of any kind pertaining to my physical and mental condition and treatment. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), mental health (not including psychotherapy notes) and alcohol and substance abuse treatment. I hereby authorize the release of this type of information.

I understand that I have the right to revoke this Authorization at any time by sending written notification to the Recipient. I understand that a revocation will have no effect on the disclosure of information made under this Authorization prior to the receipt of my revocation.

I understand that my treatment, payment, or eligibility for benefits at and by Recipient may not be conditioned on me signing this Authorization. I understand that this Authorization is voluntary.

I acknowledge that information disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient and may no longer be protected by state or federal law.

I understand that I have the right to receive a copy of this Authorization upon request. I agree that a photocopy or facsimile copy of this Authorization shall be valid and effective, just as the original.

This Authorization shall remain in full force and effect until six (6) months from the date signed, at which time this Authorization shall automatically expire.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Printed Name of Legally Authorized Representative (if applicable)

_____

Description of Legally Authorized Representative's Authority to Sign for the Patient (if applicable)

Please return this completed form to: PICKENS URGENT CARE, LLC. 744 Noah Drive, Suite 108-109. 30143, Jasper Georgia. Fax: 706 692 0280. Email: info@pickenscare.com

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