**Healthcare Release**

Authorization For Release of Protected Health Information

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize Bradley Urgent care To:

**RELEASE INFORMATION TO OBTAIN INFORMATION FROM**

Doctor or Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All Healthcare Information Consult Notes**

**All Tests, X-Ray’s, Labs, Imaging Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Services from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Through) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I consent to release information regarding ALCOHOLISM AND DRUG ABUSE Initial\_\_\_\_

I consent to release information regarding MENTAL DISORDERS AND REHABILITATION Initial\_\_\_\_

I consent to release information regarding HIV, AIDS, & SEXUALLY TRANSMITTED DISEASES Initial\_\_\_\_

**CONTINUE PATIENT CARE INSURANCE/ BENEFIT USE** I authorize Bradley Urgent Care to release or disclose to the above-named entity all of my medical records as specified above, including any special protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment.

I understand this authorization is voluntary. Bradley Urgent Care will not condition treatment, payment of enrollment in a health plan or eligibility for benefits on whether I authorize this release. I understand that this authorization will expire on \_\_\_\_\_\_\_\_\_\_\_ (enter date). In the event the date is not entered, this authorization will expire 90 days from date indicated below. I understand that I have the right to revoke this authorization at any time by notifying Bradley Urgent Care in writing. Send notice to: HIPPA Officer, Bradley Urgent Care 4021 Keith St Cleveland, TN 37312. I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal or state law. I also have the right to refuse to sign this authorization.