General Purpose Form- *Limited Patient Authorization for Disclosure of Protected Health Information*

Clinic Stamp Here

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

Facility Name /Location: _____

I authorize _____ **(urgent care facility) to disclose or provide my protected health information to the entity or individual identified below. I understand that in the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.**

Release to (Please print):	
Name:	
Address:	
City, State & Zip:	
Phone Number:	
Fax Number:	
Email Address:	

Preferred Delivery Method:

- ☐ **Mail – Paper Copy**
- ☐ **Pick Up – Paper Copy**
- ☐ **Facsimile**
- ☐ **Email Encrypted**
- ☐ **Email Unencrypted**
- ☐ **Electronic Media, if available (e.g. USB drive, CD/DVD)**

Information to be disclosed (Check all that apply)			
Dates of treatment:			
	Chart Notes / Visit Summary		**Itemized Bill / Receipt / HCFA – CMS 1500**
	Laboratory Results		**Immunizations / TB Results**
	Radiology Report		**Drug Screen Results**
	Radiology Images (CD)		**Worker's Compensation Correspondence**
	EKG		**Outside Records**
	Entire Medical Record		**Other:**

Purpose of disclosure – Please list the purpose of the disclosure or check patient request.

☐ **Patient Request** ☐ **Other (please specify):** _____

Inclusions – All types of information found in the records selected above will be provided (if applicable), including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results, or AIDS information. Specify any information you want to exclude: _____

Expirations or termination of authorization – I understand this authorization will expire one year from the date of your signature below, unless I specify an earlier termination. A photocopy of this authorization will be treated in the same manner as the original and that I will get a copy after it is signed. I must submit a new authorization after the expiration date to continue the authorization. I have the right to terminate this authorization at any time. I must notify the privacy manager, in writing, if I decide to terminate the authorization prior to the normal expiration date. (Please list an earlier expiration if less than one year): _____

Right to revoke or terminate – As stated in the Notice of Privacy Practices, I have the right to revoke or terminate this authorization, except to the extent that the provider has taken an action in reliance to the authorization prior to your termination. You may terminate this authorization by submitting a written request addressed to Facility Privacy Official at uccmedicalrecords@hcahealthcare.com or fax to 855-874-5286.

Redisclosure – The provider has no control over the person(s) I have listed to receive my protected health information. Therefore, my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of CareNow.

Non-Conditioning – There is no restriction of my treatment as a condition for signing this authorization.

Right to Copy – I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.

Marketing – I understand this request for protected health information is not for marketing purposes and, in no way, involves the sale of my protected health information. The recipient will not further exchange the information for financial remuneration.

Fax, email or mail completed form to HCA urgent care Medical Records at fax 855-874-5286, email uccmedicalrecords@hcahealthcare.com, or mail to 611 E. State Hwy 121 Ste 220, Coppell TX 75019.

Patient or Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

Internal Use - Released By: _____ **Date:** _____ **Time:** _____ **Acct #:** _____

Revised 1/26/23