

**ENCOMPASS URGENT CARE
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Print Patient full name

_____/_____/_____
Birth date

Street address

_____-_____-_____
Social Security Number
(_____)_____-_____
Home phone number

City/State/Zip

I, _____, do hereby authorize **Encompass Urgent Care-Happy Valley** to release:
patient name

_____ Discharge Summary	_____ Pathology Reports	_____ Emergency Reports
_____ History & Physical	_____ Laboratory Reports	_____ Entire Chart
_____ Progress Notes	_____ Radiology Reports	_____ Other _____
_____ Operative Notes	_____ ECG/EEG/Cardiac Cath	_____

**ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO
COMPLY WITH YOUR REQUEST (please check one)**

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO: _____
Name of Company/Agency/facility/Person

Street Address

City/State/Zip

PURPOSE OF DISCLOSURE:

____ Referral to specialist ____ Insurance ____ Workers Comp ____ Change of Doctor/Provider
____ Legal Investigation ____ Disability determination ____ Self ____ Continuing care
Other (please specify) _____

Please provide the best telephone number in the event we need to contact you (home, work or cell)
(____) _____ - _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of individual or guardian or
Personal Representative of patient's estate**

Date