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# Authorization to Use and Disclose Health Information

**Patient Name (please print):** _____ **Date of Birth:** _____

**Phone Number:** _____ **SSN (optional):** _____

I am the ☐Patient ☐Guardian ☐Other (Please specify: _____)

**I authorize AMS Urgent Care to release my health information as identified below to:**
(name, address, & phone/fax)

_____
_____
_____
_____
_____

(circle) MAIL FAX PICK-UP

**I authorize AMS Urgent Care to request my health information as identified below from:**
(name, address, & phone/fax)

_____
_____
_____
_____
_____

(circle) MAIL FAX PICK-UP

**Purpose of disclosure:** _____

**I specifically authorize the use or disclosure of the following health information (initial):**

_____ ALL medical records
_____ Radiology Reports: ALL / from _____ to _____
_____ Chart notes: ALL / from _____ to _____
_____ Labs: ALL / from _____ to _____
_____ Billing statements
_____ Other (Please List)

**** The following items must be initialed to be included in the use or disclosure of other health information:**

_____ *HIV/AIDS related to health information and/or records
_____ *Mental health information and/or records
_____ *Drug/alcohol diagnosis, treatment, and/or referral information

**Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert date of expiration)** _____.

*Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any time by giving a written notice. I understand that, if the person or entity reviewing this information is not a health care provider or a health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.*

_____

**Signature of Patient or Patient's Legal Representative** **Date**