



Urgent Care Walk-In Medical Centers

Lake Worth - West Palm Beach: 4570 Lantana Road, Lake Worth, FL 33463 Phone (561) 963-9881
Wellington - Royal Palm Beach: 11551 Southern Boulevard, Royal Palm Beach, FL 33411 Phone (561) 798-9411

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ (Patient's Name), ____/____/____ (Date of Birth)
do hereby authorize the release and disclosure of medical records and information

FROM MD NOW Medical Centers TO:

TO:

Institution, Individual, or Agency	
Street Address	
City, State, Zip	
Phone #	Fax #

The question of privacy between the facility, my attending physician, or other physician(s), and myself is waived. I fully understand that my medical record or information maintained in connection with the date(s) of service may contain mental health, alcohol and drug abuse history, Human /immunodeficiency Virus (HIV) test result, or Acquired Immunodeficiency Syndrome (AIDS) information. The medical records or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Once this information has been disclosed to the authorized party above, I acknowledge that it may be subject to re-disclosure by the recipient and my privacy may no longer be protected. Only such records or information believed necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the record that are disclosed. If I refuse to sign this authorization, my medical record will not be released.

Information requested: _____
(Specify type of information)

Purpose of the Request:

This authorization is valid for one year from the date signed or until _____. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting revocation request to the Health Information Management department.

Patient/Parental Signature: _____ Date _____

Patient/Parental Print Name: _____

Relationship to Patient: _____

Phone#: _____