MD NOW URGENT CARE

CONSENT FOR MEDICAL AND BILLING INFORMATION RELEASE

PATIENT INFORMATION

Last Name: _____ First Name: _____

Birth Date: _____ SSN (last 4): _____

I, the above-referenced patient, hereby acknowledge and give authorization for the release and disclosure of medical records and billing information as follows:

RECORDS TO BE RECEIVED FROM

Practice Name: _____

Phone No.: _____

Fax No.: _____

REQUESTED DOCUMENTATION

Dates of Service: FROM: _____ TO: _____

Information to be released:

- ☐ Progress notes
- ☐ Labs
- ☐ Digital Imaging
- ☐ Physical Therapy
- ☐ All Medical Records
- ☐ Billing records
- ☐ Other: _____

RECORDS TO BE SENT TO

Name: _____

Address: _____

City, State, Zip: _____

Phone No.: _____

Fax No.: _____

By my signature, I understand that the question of privacy between the MD Now Medical Centers, Inc., my attending physician, other physician(s), and the patient is waived. I fully understand that my medical record or billing information maintained in connection with the date(s) of service from inception until today may contain mental health, alcohol and drug abuse history, Human Immunodeficiency Virus (HIV) test results, or Acquired Immunodeficiency Syndrome (AIDS) information. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws.

Any medical records or billing 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. I further understand that my records may not have been reviewed by the provider and therefore may not be considered as full and complete records for legal purposes. Should I require a legally verified and complete copy of your records, I will have my physician or legal representative (attorney), submit a request for such records in writing along with consent for release in order to comply with HIPAA regulations.

This authorization is valid for one year from the signed date or until ___/___/_____. I understand that 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.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health and billing information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health or billing information.

Signature: _____ **Date:** _____

Print Name: _____ **Phone No.:** _____

Relationship to patient: _____

In office Picked up by (if applicable): _____