exer URGENT CARE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

Patient DOB: _____ Patient Phone No.: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Exer Medical Corporation (Exer Urgent Care) to release to:

_____

(Persons/Organizations authorized to receive the information)

_____

(Address – street, city, state, zip code)

The following information:

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

   ☐ Only the following records or types of health information (including any dates):

   _____

   _____

b. I specifically authorize release of the following information (check as appropriate):
   - ☐ Mental health treatment information *(initial)*_____
   - ☐ HIV test results *(initial)*_____
   - ☐ Alcohol/drug treatment information *(initial)*_____

PURPOSE

Purpose of requested use or disclosure:

- ☐ Patient request
- ☐ Other: _____

Limitations, if any: _____

EXPIRATION

This authorization will automatically expire one (1) year from the date of execution unless a different date is specified *(insert date, if any):* _____

DELIVERY METHOD:
- ☐ Pick up
- ☐ Mail to: _____

MY RIGHTS

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Exer Urgent Care, 2381 Rosecrans Avenue, Suite 115, El Segundo, CA 90245. My revocation will be effective upon receipt, but will not be effective to the extent that others have acted in reliance upon this Authorization. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless specifically required or permitted by law. I understand I am entitled to receive a copy of this Authorization.

I hereby release my treating physicians and their associates, and Exer Urgent Care and its respective employees and agents from any liability from the release of this information. I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

SIGNATURE

Date: _____ Time: _____ ☐AM - ☐PM

Signature: _____
(patient/legal representative)

If signed by a person other than the patient, indicate relationship*: _____

Print name: _____
(legal representative)

Phone number: _____

**Legal Representative must bring valid ID and proof of authority to act on behalf of patient.*