Date: ______/______/________

Patient Name: ________________________________

MEDICATION ACCESS AUTHORIZATION

☐ **I authorize PUC to obtain/download medication information from my pharmacy.**

☐ **I DO NOT authorize PUC to obtain/download medication information from my pharmacy. I acknowledge by choosing this option, I may be limiting my quality of care.**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your physician or the staff of **Physicians Urgent Care (PUC)** to give copies of and/or discuss your condition, exams, procedures, and/or x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

☐ **I DO NOT authorize PUC to release any information concerning my care to any individual.**

☐ **I authorize PUC to release any/all information including verbal information, copies of x-rays and medical paperwork concerning my medical care to the following individuals:**

Name: ________________________________**Relationship:** __________________**Phone#:** ____________________

Name: ________________________________**Relationship:** __________________**Phone#:** ____________________

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy implemented through the Health Insurance Portability and Accountability Act of 1996, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

☐ **I DO NOT authorize PUC to release any information concerning my care to any individual:**

☐ **I authorize PUC to release/discuss financial information with the following individuals.**

Name: ________________________________**Relationship:** ____________________**Phone#:** __________________

Name: ________________________________**Relationship:** ____________________**Phone#:** __________________

AUTHORIZATION TO LEAVE PHONE MESSAGE

☐ **I authorize PUC to leave detailed messages at phone number:** __________-__________-____________

☐ **I DO NOT authorize PUC to leave a detailed message on my answering machine or voicemail. I acknowledge in choosing this option that I, the patient/guardian, assume full responsibility for contacting PUC regarding any/all testing results.**

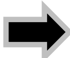
E-MAIL AUTHORIZATION

Yes, I would like healthcare-related information emailed to the address listed. PUC does not share/sell addresses.

____ @ ____________________________ . ___________

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how PUC may use and disclose my protected health information. I understand that PUC reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.



Signature of Patient or Parent/Guardian: ____ **Date**: ____/____/_____