Friendswood Urgent Care
1305 West Parkwood Suite 101
Friendswood, Texas 77546
Tel: 281-648-4800/ Fax : 281-648-4803

Authorization for Release of Information to Designated Person(s)

Patient Name: _____Date of Birth:_____
This form is part of the Federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Friendswood Urgent Care to release information regarding your healthcare.

Person(s) who can receive information for you:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I hereby authorize Friendswood Urgent Care's staff to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Friendswood Urgent Care in writing. I understand that once this information is disclosed the released information may no longer be protected by federal privacy regulations. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effective until revoked by the patient or representatives signing the authorization.

_____ _____
Patient Signature or Guardian, if patient is a Minor Date