

**Grand Prairie Urgent Care
5204 S. Hwy 360, Suite 400
Grand Prairie, TX 75052
Tel: (972) 755-1785/ Fax : (972) 602-4522**

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 Grand Prairie 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 Grand Prairie 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 Grand Prairie 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