

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Gwinnett Urgent Care to furnish medical information concerning:

(Patient)

Patient DOB _____. SSN _____.

Medical information is released to the following:

_____ M.D. , _____ Medical
Center/Clinic/Hospital, or (other)_____.

Send Information via FAX to; _____,

Or Mail to: _____

Any and all information may be released, including but not limited to Dates of Service, X-Ray and/or Laboratory results, Treatment, Diagnosis, or any other accessible medical records.

This authorization is effective now and will remain in effect until withdrawn.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____
(Patient)

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
- spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)