AUTHORIZATION TO RELEASE MEDICAL RECORDS

FROM GWINNETT URGENT CARE

I, _____authorize Gwinnett Urgent Care to release my medical records to the following person or organization:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Fax Number: _____

I understand that this information will include any and ALL treatment plans, medication issues, history of Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted diseases, Human Immunodeficiency Virus (HIV) infection, behavioral health/psychiatric care and evaluations, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should NOT be released: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

This form is valid for one year from patient signature date.