Release of Personal Health Information (PHI) and Assignment of Consent

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act---45 CFR Parts 160 and 164)

Patient Name: ____ DOB:_________________

Phone: _________________________________ MRN# (Office Use):_______________________

E-mail Address: ____

I hereby authorize **CityDoc Urgent Care Center** to release the personal health information on the above named patient to the individual(s) listed below. If I am the parent/guardian of a minor patient named above, I also authorize these individuals to act on my behalf to provide consent for treatment of medical care during the period of my absence. I assign consent to provide treatment and agree to release medical information to these individual(s) on the above named patient:

Authorized Individuals to Receive PHI and Consent for Treatment:

Name: _____________________________Relationship:_________________Phone: ______________

Name: _____________________________Relationship:_________________Phone: ______________

Name: _____________________________Relationship:_________________Phone:______________

I acknowledge that I can obtain a copy of CityDoc Urgent Care Center's Notice of Privacy Practices at any CityDoc location or online at www.citydoc.net.

This authorization shall remain in effect indefinitely until I revoke, in writing.

Patient/Parent/Guardian Printed Name: ____

Patient/Parent/Guardian Signature:___________________________________ Date _____________