AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

METRO URGENT CARE
123 Concord Plaza St. Louis, MO 63128

List of Information Requested:

1._____
2._____

Persons Authorized to Disclose Information

* Name:
* Address:
* Phone:

Persons Authorized to Receive and Use Information

* Name:
* Address:
* Phone:

Purpose of Disclosure:

[ ] Continuing medical care
[ ] At the request of the individual patient
[ ] Other

Expiration Date of Authorization:

This authorization is effective for six months unless revoked or terminated by the patient or the patients personal representative.

Right to Terminate or Revoke Authorization

You may revoke of terminate this authorization by submitting a written revocation to Metro Urgent Care.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Your refusal to sign this authorization will not affect your ability to obtain treatment, or eligibility or payment of health care benefits.

Name of Patient (PRINT) Patients Contact Phone Number

Patient's DOB

Patient's Signature Date

Witness Date