Masonboro Urgent Care 6132 Carolina Beach Road, Suite 8 Wilmington, NC 28412 Phone 910-794-4947 Fax 910-794-4943

HIPAA RELEASE

Authorization for Use and Disclosure

Masonboro Urgent Care Release Information to Others

	Patient Name:		*			
	Last	First	MI	Maider	or Other Name	
	Date of Birth:	Medical Record #:		Phone:		
	Address:	City:		ST:	Zip:	
		All dates of Service				
pι	☐ I authorize Masonboro Ur urposes of treatment, payment, an	_	ose my protecto	ed health infor	mation for its own	
	☐ I authorize Masonboro Urgent Care to disclose the following records related to the date above:					
	Records: All records	☐ Diagnostic Records (lab, x-ray, etc.) ☐ HI				
	Please release these records to: ☐ COVERED ENTITY or ☐ INDIVIDUAL LISTED BELOW NAME:					
				CTATE.	7ID.	
	ADDRESS:					
		PHONE:FAX:				
	If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations. You may revoke this authorization in writing at any time by sending written notification to: OR FAX 910-794-4943					
	Masonboro Urgent Care 6132 Carolina Beach Road, Suite 8 Wilmington, NC 28412					
	Please note: Revocations do not apply to information that has already been disclosed or used					
	before revocation has been received. You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity. You have the right to receive a copy of this authorization.					
	This authorization expires one year from date of signing or on					
		OR	RENT/LEGAL GUAR			
	SIGNATURE OF PATIENT					
		RE	LATIONSHIP TO PAT	TENT		