AUTHORIZATION TO RELEASE MEDICAL RECORDS

FROM BRASELTON URGENT CARE

I, ____authorize Braselton 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.