



Date ____ / ____ / ____

PATIENT INFORMATION

Name _____
Last First MI

Address _____
Street Apt # City State Zip

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

DOB ____ / ____ / ____ SSN ____ - ____ - ____ Age ____ Sex: M F

Emergency Contact _____
Name Phone Relationship

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

Name _____
Last First MI

Address _____
Street Apt # City State Zip

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

DOB ____ / ____ / ____ SSN ____ - ____ - ____ Relationship to Patient _____ Sex: M F

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Benefit Phone _____

Subscriber ID # _____ Group # _____

RELEASE OF INFORMATION

I authorize Urgent and Family Care, LLP and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?
 All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).
 No information whatsoever

To whom can we release information (please list names):

 No one except the patient can obtain information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand Urgent and Family Care at Avery Ranch, LLP Financial and General Office Policies. My signature indicates compliance and understanding of these policies. I also understand that a copy of these policies can be provided to me upon request.

Signature of Patient/Guardian _____

Date _____