Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Visit Health Urgent Care's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Patient / Guardian Signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____

Acknowledgment to Release Medical Records

I authorize Visit Health Urgent Care to release my:

- ☐ Name, address, phone, SSI#
- ☐ Diagnosis/ Health status
- ☐ X-rays / Diagnostic tests / Results
- ☐ Insurance policy information
- ☐ Laboratory tests / Results
- ☐ Immunization records
- ☐ Physical examination results
- ☐ Employer information
- ☐ Confidential information (HIV, STD, substance abuse, mental health info/results)

To (name the person or entity): _____

For the purpose of: _____

By means of:
- ☐ Email
- ☐ Phone
- ☐ Mail
- ☐ Other _____

I give permission to Visit Health Urgent Care to release my PHI, and if I refuse to authorize the release of my health information, Visit Health Urgent Care may refuse to treat me.

Patient / Guardian Signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____

Consent to Treatment

I consent to being treated at Visit Health Urgent Care. I consent to the release of information from medical records to any insurance carrier or organization requiring same.

Patient / Guardian Signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____