Guilford Immediate Care
1250 Jesse Jewell Parkway, Suite 400
Gainesville, GA 30501
(770)532-0800

______________________ ______________ ______________
(PLEASE PRINT- Patient's Full Name) (Date of Birth) (Social Security Number)

______________________ ______________ ______________
(Patient's Mailing Address) (City, State, Zip Code) (Telephone Number)

1. I understand that this authorization is completely voluntary. I also understand that if the organization authorized to receive the Information is not a health plan or health care provider; the released Information may no longer be protected by federal privacy regulations.

   a. Facility/physician authorized to disclose my protected health information (check one):
   _________ Guilford Immediate Care

   __________ Other (print complete name and address)

   ____

   ____

   ____

2. a. I hereby authorize the above name facility/physician to release any or all of my protected health information including, if applicable, records relating to the following conditions: mental, psychiatric, alcohol, drug abuse, AIDS, or HIV test results.

   b. Specific description of Information to be used and/or disclosed, including date(s):

   ____

   ____

3. a. Facility/physician authorized to receive my protected health information (print complete name and address)

   ____

   ____

   ____

   b. For what purpose? ______________________

4. This authorization will expire on ______________________. I understand that upon expiration of this authorization, no further use or disclosure may be made. I also understand that I may revoke this in writing, except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to the Privacy Officer at Guilford Immediate Care.

I understand that I may be declined treatment if I refuse to sign this authorization only when: (1) the treatment is for the sole purpose of creating protected health information for disclosure to a third party pursuant to this authorization: or (2) the treatment is related to a research project and this authorization if for the use and/or disclosure of information for such research.

I understand that a copy of this form will be provided upon request.

______________________ ______________
(Signature of Patient or Patient's Legal Representative) (Today's Date)

______________________ ______________
(Printed Name of Legal Representative) (Relationship to Patient)