Summit Urgent Care, LLC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION BY A THIRD PARTY

Information about the Patient:

Patient Name: ______________________________ (Last / First / Middle) DOB: ____/____/______

Address: ______________________________ Phone: ______________________

The Patient identified above hereby authorizes and requests the following organization or person (the "Responder"):

Name: ______________________________

Address: ______________________________ (Street Address / City / State / Zip Code)

Phone: ______________________________

to release and disclose the Patient's Protected Health Information as defined by HIPAA ("PHI") to (please select one):

Summit Urgent Care, LLC

☐ 1825 Highway 34 East, Ste 1200, Newnan, GA 30265

☐ Fax: (770) 502-2113

The Patient requests the PHI to be provided to Summit Urgent Care, LLC as follows, *if Other Than by Mail or Fax*:

_____ Electronic copy Electronic Format Requested: ______________________ ______ Other (describe on a separate sheet)

This Authorization applies to the following PHI:

- ☐ All Records pertaining to: ______________________________
- ☐ Other: ______________________________
- ☐ This Authorization applies only to the following dates of service: ____/____/____, ____/____/____, ____/_____/____.
- ☐ This Authorization applies only to the dates of service during the period of time: From: ____/____/____ To: ____/____/____.
- ☐ Records of testing, care, treatment or research pertaining to HIV, AIDS or other communicable diseases
- ☐ Records of treatment for drug and/or alcohol dependency or abuse
- ☐ Records of mental health treatment, psychological services, social services, including communications made to a social worker or psychologist

Information about the person or organization <u>Authorizing</u> the disclosure of PHI, *if Other Than the Patient Listed Above*:

Name: ______________________________

Relationship to Patient: ______________________________ ☐ Documents of Relationship to Patient Attached

Address: ______________________________ Phone: ______________________________

I understand that: (i) authorizing the disclosure of PHI to Summit Urgent Care, LLC ("Practice") is voluntary, (ii) this Authorization covers multiple requests for and disclosures of PHI and authorizes Practice to make such requests and the Respondent to respond to such requests; (iii) I may refuse to provide authorization for disclosure of PHI to Practice, and Practice may not condition treatment, payment for services, or eligibility for benefits on whether I sign this Authorization; (iv) Practice, as a Covered Entity under HIPAA, is required to keep PHI private and secured; however, any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal or state privacy rules; and (v) Practice must provide me a copy of this signed Authorization.

This Authorization may be revoked at any time in writing by providing a signed revocation to the Responder's address listed above. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid. If not previously revoked, this Authorization shall expire one (1) year from the date of the Patient's last visit to Practice.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION, PRACTICE MAY NOT BE ABLE TO OBTAIN PHI FROM THE RESPONDENT, AND Practice IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF SAME AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT I WILL NOT HOLD PRACTICE AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF MY REFUSAL TO PROVIDE THIS AUTHORIZATION, REVOKING THIS AUTHORIZATION, AND/OR IN CONNECTION WITH ANY DISCLOSURE OF PHI PURSUANT TO THIS AUTHORIZATION.

Patient's Signature: ______________________________ Date: ___/___/_____

Patient's Authorized Representative's Signature: ______________________________ Date: ___/___/_____

For Office Use Only:

If Patient is unable to sign, secure signature of Next of Kin or Legal Agent/Guardian and indicate reason why Patient is unable to sign:

☐ Minor ☐ Disoriented

☐ Incompetent ☐ Medically Unstable

Processor's Initial's ______________ Date Sent Out: ____/____/_____