URGENT CARE ELEVEN

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize **Urgent Care Eleven, LLC** to release confidential health information about me, by releasing a copy of medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth:_____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:_____

Address:_____

City, State, Zip Code:_____

The purpose/reason for this release of information is as follows:

_____

_____

_____ _____

Signature of Patient Date