



Today's Date: _____ Reason of Visit: _____

Patient Name: _____ Gender: M / F

Patient Date of Birth: _____ SS# _____

Address: _____

_____ Phone#: _____

City State Zip code

Authorization for Medical Records Release and Communication

I authorize the person's listed below to have verbal communication with our Doctor and staff.
I also authorize release of medical records to those listed below:

_____	Relation	YES	NO
_____	Relation	YES	NO
_____	Relation	YES	NO

Patients Signature: _____

Note:

*** Records will not be released without the proper identification. PLEASE advise the individual picking up your records to bring photo identification such as a driver's license.**

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I have been informed of the Notice of Privacy Practices from MEDSTAT Urgent Care Centers PL concerning how the use of disclosure of Protected Health Information will be handled by the practice. A copy of this notice is posted in the office reception area (copies are also available for viewing at all magazine tables in lobby). I understand I can also receive a copy of this notice.

Signature: _____ **Date:** _____

Your relation to the patient (if applicable): _____