YOUR FAMILY MEDICAL GROUP

ORTHO EXPRESS by URGENT CARE Berwick, Sandfly, Midtown & Wilmington Island | URGENT CARE of Berwick, Sandfly, Midtown & Wilmington Island | PRIMARY CARE Savannah

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **E-mail Address:** _____

I authorize Your Family Medical Group to release:

____ Medical Records

- All medical records? _____
- Medical records only related to: _____

  _____

____ Lab Results

- Type of Lab Orders: _____

____ Other

- Please specify content: _____

Please indicate the relevant date(s) of service, either by range or specific dates:

_____

_____

_____

Please release the above information to:

Name or Organization: _____

Address: _____

Relationship to Patient: _____

Phone Number: _____ **Fax Number:** _____

E-Mail Address: _____

Reason for release: _____

How would you like the information disclosed to designated contact?

___ Fax
___ E-Mail
____ Phone
____ In Person *(We require designee to bring photo ID for information to be released.)*

I understand that I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization.

I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release Urgent Care of Berwick from all liability which may arise because of my authorized release of records.

Patient (or legal representative): _____

Date: _____/_____/_____

Relationship to Patient: _____

Witness: _____