|  |  |
| --- | --- |
|  |  |
| **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**  AUTORIZACIÓN PARA LIBERAR INFORMACIÓN MÉDICA | |

|  |  |
| --- | --- |
| **Name/Legal Guardian (Nombre/Guardian Legal)** | |
| **Address (Direccion)** | |
| **Phone Number (Numero de Telefono)** | **E-mail (Correo Electronico)** |
| **Date of Birth (Fecha de Nacimiento)** | **Last four of Social Security Number (Ultimos 4 Numeros del Social) \_\_\_\_\_\_\_\_\_\_\_\_\_** |

I hereby authorize Xcel Urgent Care, LLC, to release my entire medical, treatment and diagnostic record to:

Por la presente yo autorizo compartir toda mi informacion medica, tratamiemtos y diagnosticos para:

|  |  |  |
| --- | --- | --- |
| **Person/Organization to Receive Information (Persona/Organizacion para Recibir Informacion)** | | |
| **Street Address (Direccion)** | | |
| **City (Ciudad)** | **State (Estado)** | **Zip Code (Codigo Postal)** |
| **Phone Number (Numero de Telefono)** | **Fax Number (Numero de Fax)** | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's/Legal Guardian Signature

(Paciente o Guardian Legal Firma)

Print Name (Nombre Escrito) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (Fecha) \_\_\_\_\_\_\_\_\_\_\_\_