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

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| **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:

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| **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)** |

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Patient's/Legal Guardian Signature

(Paciente o Guardian Legal Firma)

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