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

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| **Name/Legal Guardian. Nombre/Guardian legal**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address. Direccion** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Phone Number. Numero de telefono**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **E-mail. Correo electronico** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Birthdate. Fecha de nacimiento**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last four of Social Security Number. Ultimos 4 numeros del social.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Person/Organization to Release Information. Persona/Organizacion para darle informacion** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Street Address. Direccion de calle.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **City. Ciudad**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **State. Estado**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Zip Code. Codigo postal** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Phone Number. Numero de telefono** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Fax Number. Numero de fax** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I hereby authorize. Por la presente yo autorizo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release my entire medical, treatment and diagnostic record to. A compartir toda mi informacion medica, tratamiemtos y diagnosticos para:

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|  **Person/Organization to Receive Information****XCEL URGENT CARE LLC** |
|  **Street Address** **3517 S Jefferson Street** |
| **City****Falls Church** | **State****VA** | **Zip Code****22041** |
| **Phone Number****844-923-5227** | **Fax Number****703-986-3883** |

I understand and agree that my health information will be used only by Xcel Urgent Care LLC unless subpoenaed by appropriate authorized state or federal agencies. Entiendo y acepto que mi información médica será utilizada únicamente por Xcel Urgent Care LLC a menos que sea citado por las agencias estatales o federales autorizadas correspondientes.

Patient's/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (paciente o guardian legal firma)

Print Name. Nombre escrito \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date. Fecha \_\_\_\_\_\_\_\_\_\_\_\_