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