Medical Information Release Form
(HIPAA Release Form)

Your privacy is important to us here at Urgent Care of Stuttgart. As a result, we ask that you complete the following release form related to your personal protected health information (PHI) and health-related benefits.

PLEASE PRINT ALL INFORMATION

Patient Name: _____ Patient Date of Birth: ____/____/____

I authorize Urgent Care of Stuttgart and/or Experity (billing company) to release information about my medical treatment including the diagnosis, records and examinations rendered to me and information regarding my account including claims information released to the name(s) listed below.

PRINT NAME RELATIONSHIP

1. _____
2. _____
3. _____

( ) Information may not be released to anyone

A) I may revoke this authorization at any time by giving written notice to Urgent Care of Stuttgart. I understand that my revocation will not affect any use or disclosure of my PHI that was made in reliance on the authorization before I revoked it.

B) My health provider cannot require me to sign this authorization in order to be eligible for services or treatment.

C) It is possible that the persons who receive information based on this authorization may disclose it to others and as a result the information may no longer be protected by federal privacy rules.

D) This authorization for my personal health information does not apply to the release of the same information for any spouse or child that I may cover on my medical benefits or account at Urgent Care of Stuttgart. I understand that my spouse or child over 18 must provide an independent authorization for release of their personal PHI.

By signing below, I agree that I have read and understand the terms of this agreement.

_____ _____

PATIENT OR GUARANTOR SIGNATURE **TODAYS DATE**

_____ _____

PRINT NAME OF GUARANTOR (IF PATIENT IS A MINOR) **RELATIONSHIP**