Authorization for Disclosure of Health information

Urgent Medicine Associates, LLC
2829 University Drive South, Ste 101
Fargo, ND 58103
(701) 232-9000
(701) 893-9057 (fax)

Patient Name: _____
Address: _____
_____
Birthdate: _____

To: _____
_____
_____
_____

To have records sent *from UrgentMED to your primary/personal doctor*, complete this box.

☐ By my signature below, I am authorizing Urgent Medicine Associates/UrgentMED to **release** information to my personal physician that I would appreciate having reviewed and added to my medical record. Thank you.

To have records sent *from your doctor to UrgentMED*, complete this box.

☐ By my signature below, I **request** that you provide copies of my medical record by fax or mail to Urgent Medicine Associates/UrgentMED as pertaining to:

☐ Clinic Notes ☐ Other: _____

☐ Lab/X-ray/EKG (circle)

☐ All records Dates: _____

This authorization will remain valid for a period of one year from the date of signature, unless I revoke this decision in writing which I may do at any time.

I understand that my health information is protected, confidential and will be shared only with medical personnel as pertains to my medical care.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

_____
(Print Witness Name)