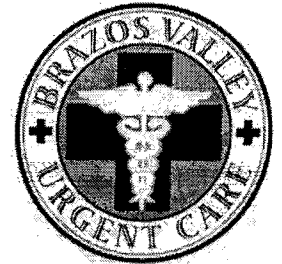




Brazos Valley Urgent Care
 2911 Texas Ave. South
 Suite 103
 College Station, TX 77840



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize **Brazos Valley Urgent Care** to ___ release to: ___ receive from:

Person or Organization: _____

Address: _____ Phone: _____

Fax (if applicable): _____

Information/copies from the medical records on:

Patient: _____ Date of Birth: _____

Social Security: _____ Date of Service: _____

INFORMATION TO BE RELEASED: (Please check)

___ Entire Record ___ Radiology Reports ___ Lab ___ Pathology Report ___ Billing
 ___ Immunization Reports ___ HIV test results ___ AIDS information
 ___ History and physical ___ other _____

This information is being released for the following purpose: (Please check)

___ Continued care ___ Attorney/Litigation ___ Insurance ___ Disability Services
 ___ Other _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here: _____

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits from making any further disclosure of it without specific written consent of the person to whom it pertains, other information is not sufficient for this purpose.

FOR PATIENTS RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

 Signature of Patient or Legally Authorized Representative

 Date

 Relationship to Patient

 Witness- Printed name/Signature

 Date