Authorization for Disclosure of Health information

2829 University Drive South
Fargo, ND 58103
(701) 232-9000
(701) 893-9057 (fax)

Patient Name: _____
Address: _____
_____
Birthdate: _____

To: _____
_____
_____
_____

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

❑ By my signature below, I **request** that you provide copies of my medical record by fax or mail to Urgent Medicine Associates, LLC.

❑ 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: _____ Date: _____

_____
(Printed)