Fax :(586)722- 7446
Email: kashaturgentcare@gmail.com

Kashat Urgent Care

Patient Name _____

Patient DOB. _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION – AMBULATED SETTING

I, _____hereby authorize _____
Its Director or Designee, or Health Information Management/ Medical Records Department, to release protected health information, including alcohol and drug abuse records protected under the regulations in Title 42 Code of Federal Regulations, Part 2, if any; behavioral medicine services records, if any, including communications made by me to social worker or psychologist; and any information regarding communicable diseases and infections as defined by MCLA 333.5121, if any, which includes venereal disease, tuberculosis, HIV, AIDS, to individuals or organization listed below, only under the conditions listed below:

1. Name of person(s) or organization(s), to whom disclosure is to be made:
   Name _____
   Street Address _____
   City _____ State _____ Zip Code _____
   I understand that my protected health information disclosed under this Authorization may be subject to redisclosure by the individual or organization named above and its privacy will no longer be protected by the law.

2. The authorized person must place their initial next to the specific type(s) of information to be disclosed.
   _____ Office Records Dates of Service _____
   _____ X-ray Reports Dates of Service _____
   _____ Laboratory Tests Dates of Service _____
   _____ Immunization Records Dates of Service _____
   _____ Information regarding _____
   _____ Other Describe records required and give approximate date(s) of service:
   _____

3. The purpose and need for such disclosure:
   - ☐ Employer Request
   - ☐ Disability Certification
   - ☐ Continuation of Care
   - ☐ Social Security
   - ☐ Insurance Claim
   - ☐ Consultation
   - ☐ Social Service
   - ☐ Insurance Application
   - ☐ School Requirement
   - ☐ Worker's Compensation
   - ☐ Attorney inquiry
   - ☐ Personal Use
   - ☐ Other (specify) _____
   - ☐ Research

4. This authorization can be revoked, in writing, at any time except to the extent that information has already been released or disclosed. Any authorization for the release or disclosure of drug and alcohol abuse records shall end when the purpose for the release has been achieved.

5. This authorization will expire automatically when the purpose for the release or disclosure has been achieved or upon 90 days after the date below, whichever is later.
   Signature of Patient _____ Date _____ Time _____
   Birth Date of Patient _____ Social Security Number of Patient _____
   Consent of legal guardian, patient advocate or personal representative, if patient is incapable or is a minor.
   Signature of guardian, patient advocate,
   Or personal representative _____ Date _____ Time _____
   Relationship _____
   Address_____
   _____
   Phone Number _____ Witness _____