MARTINSVILLE URGENT CARE

1044 East Church Street
Martinsville, Virginia 24112
(276) 634-0010 phone (276) 632-0120 fax
Email: martinsvilleurgentcare@comcast.net

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____

SSN:_____ DOB:_____

hereby authorize and request that _____release my medical records to:

Name:_____

Address:_____

_____

_____ I will pick up this record _____ I give my permission to fax records

_____ I would like these records mailed directly to Martinsville Urgent Care.

Medical Information Requested:

_____ Complete Record

_____ Limited to these areas only:_____

Please specify reason for release of information, ie continuing medical care, second opinion, etc._____

This authorization will automatically expire 60 days from the date of signature.
At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to Martinsville Urgent Care. I understand that any information which was released prior to my revocation was in compliance with this authorization and shall not constitute a breach of my rights to confidentiality.

_____ _____
Patient Signature Date

OFFICE USE ONLY:
Released By:_____ Date:_____

Method:_____