1618 Mars Hill Rd, Watkinsville, GA 30677 Ph:706-705-4543

# HIPAA Release

**Patient Information:** (required fields marked with a *)

First Name*: _____ Last Name*: _____

Date of Birth*: _____ Mobile Phone* (or best number) :_____

Email Address*: _____ Home Phone: _____

## Section I:

I give my permission for PrimeTime Urgent Care/PrimeTime Pediatrics to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

## Section II Health Information:

I give permission to:

- ○ Disclose my complete health record, including, but not limited to, diagnosis, lab test results, treatment, and billing records for all conditions.
- ○ Disclose my complete health record except for the following information (Do NOT Disclose):
  - ○ Mental Health Records
  - ○ Communicable Diseases including, but not limited to, HIV and AIDS
  - ○ Alcohol/drug abuse treatment records
  - ○ Other: _____

## Section III Reason for Disclosure:

Reason for Disclosure:

- ○ Continuing Care
- ○ Personal Use
- ○ Other

## Section IV Who Can Receive My Health Information:

We will automatically share your information with your primary care doctor unless you notify us in writing that you do NOT want your records released.

I give authorization for the health information detailed in Section II of this document to be shared with the following individual(s) or organization(s). I understand that the person(s) listed below may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

First Name: _____ Last Name: _____

Email: _____ Phone (or best number): _____

## Section V Duration of Authorization:

This authorization to share my health information is valid for:

- ○ All past, present, and future periods
- ○ 12 months from today
- ○ From today's date until: _____

## Section VI Signature:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to PrimeTime Urgent Care/PrimeTime Pediatrics; 1618 Mars Hill Rd Ste A; Watkinsville, GA 30677.

I understand, in the event that my information has already been shared, that it may be too late to cancel permission to share my health data by the time my authorization is revoked.

I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

I understand that the failure to sign/submit this authorization or the cancellation of the authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Patient Name*: _____ Patient DOB*: _____

Signature:* _____ Today's Date*: _____

Signed by (if different from patient): Name*: _____

Relationship to patient*: _____