Medical Information Release Form (HIPAA Release Form)

Name:_____ Date of Birth: _____

Release of Information

You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts") or to collect amounts you may owe, Makana North Shore Urgent Care, and its officers, agents, affiliates, employees, and any affiliated, or associated service providers and any third-party debt collection agency associated therewith (collective, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, or using any email address you provide us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Employer: _____
- ☐ Other: _____
- ☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My home My work ☐ My mobile number _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day) _____between (time) _____

Signed: _____ Date: _____

Witness:_____ Date: _____