MAIN STREET Urgent Care
A Minor Emergency Clinic

1421 S. Main Street, Ste 111, Boerne, TX 78006
Office: (830) 249-9995 Fax: (830) 249-9868
1426 E. Main St., Ste 300, Fredericksburg, TX 78624
Office: (830) 997-9995

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, _____ (first and last name), _____ (date of birth), hereby give my permission to Main Street Urgent Care, Quality Urgent Care, PA, to release the following information (check all that apply):

- ☐ Entire Health records (including, but not limited to, information regarding medical treatment, insurance, demographics, referral documents, and records from other facilities)
- ☐ Lab test results (urine analysis, drug screen, etc.)
- ☐ Radiology reports/exams
- ☐ X-ray films or other images
- ☐ HIV, AIDS and other communicable disease test results
- ☐ Drug and alcohol abuse treatment records
- ☐ Psychiatric/Mental Health treatment records
- ☐ Other: _____

Dates of Treatment: From: _____ To: _____

I authorize this information to be disclosed in the following ways:

☐ Written ☐ Fax

The information is to be disclosed to: _____
Address: _____
City, State, Zip: _____
Contact Person: _____
Phone/Fax: _____

Purpose of this disclosure: _____

Expiration Date of Authorization: This authorization is effective through ____ / ____ / ____ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Main Street Urgent Care. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure: I understand my information may be mailed, faxed or picked-up in person. The person or organization sent or transporting the disclosed information under this authorization my disclose information again. It may not be possible to ensure your right to the protection of the privacy of this information once Main Street Urgent Care releases/discloses it to another party.

Rights of the Individual: You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization.

Effect of Refusing Authorization: If you refuse to sign this authorization, Main Street will not deny you any treatment except treatment that you have requested for the purpose of disclosure to others.

SIGNATURE

_____ _____ _____
Signature Patient Name Date

_____ _____
Name of Patient Representative Signing for Patient Relationship of Patient Representative to Patient
(required if the patient is a minor or an adult who is unable to sign this form)