AvaMed
URGENT CARE

205 TOM HILL SR BLVD STE B MACON, GA, ZIP 31210 Ph: 404 464 0304

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to AVAMED URGENT CARE upon request in person, by fax, or by mail to the address or fax number specified at the time of the request.

Provider: _____

Patient: _____

DOB: _____ SS#: _____

Records authorized to be released: ALL RECORDS ON PATIENT

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that AVAMED URGENT CARE may re-disclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____

Patient or Authorized Representative Date

_____ _____

Name of Representative Relationship to Patient

Please email requested records to avamedcare@outlook.com.