exer URGENT CARE

SPORT PHYSICAL AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Please read carefully before signing.

Name of patient: _____

Patient DOB: _____ Patient Phone No.: _____

Use And Disclosure Of Health Information

I hereby authorize Exer Urgent Care (Exer Medical Corporation) and Facey Medical Foundation to release to:

_____

(School Authorized to receive the information)

_____

(School Address – street, city, state, zip code)

The following information: _____

_____

Purpose

Purpose of requested use or disclosure:

□ Patient request
□ Other: _____

Expiration

This authorization will automatically expire one (1) year from the date of execution unless a different date is specified *(insert date, if any)*: _____

My Rights

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to: Exer Urgent Care, 390 N Pacific Coast Highway, Suite 3000, El Segundo, CA 90245. My revocation will be effective upon receipt, but will not be effective to the extent that others have acted in reliance upon this Authorization. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless specifically required or permitted by law. I understand I am entitled to receive a copy of this Authorization.

I hereby release my treating physicians and their associates, and Exer Urgent Care and Facey Medical Foundation and their respective employees and agents from any liability from the release of this information. I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

Signature

Date: _____ Time: _____ ☐AM - ☐PM

Signature: _____
(patient/legal representative)*

Print Name: _____ Phone number: _____

*Legal Representative must bring valid ID and proof of authority to act on behalf of patient.