Release of Medical Information and Registration

MedAccess URGENT CARE, PLLC

******Please print all information below******

Last Name: _____ Legal First Name: _____ Middle Initial: ____

Social Security # _____ ____ _____ Date of Birth ___, ___, ____ Sex: ☐ M or ☐ F

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Alternate Phone _____

Work Phone _____ Ext _____

Company who sent you: _____ Job Title: _____

Employer, if different from the Company that sent you _____

Work Location _____

Check reason for your visit: ☐ Physical ☐ Drug Screen ☐ Injury ☐ Other: _____

If injury, please describe body part involved: _____

Date of injury: ___ ___ _____ - Required

Have you been treated for this injury: ☐ Yes ☐ No Date of that visit: _____

If yes, which medical facility _____

Have you ever been seen at any other MedAccess Urgent Care, PLLC location? ☐ Yes ☐ No

CONSENT FOR TREATMENT

_____ INITIAL HERE

I hereby certify that the foregoing information is true and complete to the best of my knowledge. I request medical treatment described above in conjunction with my above referenced employment (either current or potential).

ACKNOWLEDGEMENT OF NOTICE AND PRIVACY PRACTICES

_____ INITIAL HERE

I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that MedAccess Urgent Care, PLLC (MAUC), the providers, medical assistants and other MAUC staff may use and share my confidential health information with others in order to treat e, in order to arrange for payment of my bill and for issues that concern MAUC's operations and responsibilities.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION*

**Please note that this section does not pertain to self-pay patients.*

I authorized MedAccess Urgent Care, PLLC to release such medical records and information regarding any aspect of my treatment or diagnosis received during my treatment to the above identified employer, and/or their agents or representatives for the purpose of my employment or potential employment with the Employer. In addition, I authorize the release of my medical records and any information regarding my diagnosis and medical condition to any other health professionals involved in my care, for the purpose of continuing to treat me.

ATTENTION: Please be advised that once MedAccess Urgent Care releases this information to the Employer the released information is under the control of the Employer where it is maintained in Employee records. Further, the release information may be subject to re-disclosure by the Employer. I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug and /or alcohol treatment or use

I understand that:

- I am here at the request of the identified Employer;
- MedAccess Urgent Care is treating me and creating health information that will be disclosed to the Employer;
- I must sign the Authorization for Release of Information form as a condition of receiving treatment from MedAccess Urgent Care; and
- If I do not sign this form, MedAccess Urgent Care may not treat me as requested by the Employer and will not send this information to the identified Employer.

If I decide to obtain treatment from MedAccess Urgent Care without signing this form, and MedAccess Urgent Care decides to provide such treatment, I will pay for all of the services that MedAccess Urgent Care provides.

I understand and agree that this Authorization is valid for as long as MedAccess Urgent Care, PLLC stays in business.

I agree that I have received a signed copy of this Authorization if I chose to receive it.

_____ _____

Signature of Patient 

Date