AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Federal and/or state law, as applicable, requires that Superior Urgent Care obtain your authorization to use or disclose your protected health information in certain circumstances. We are requesting your authorization because federal and/or state laws require it under the circumstances described more fully below.
Please read all statements on this form carefully, as it describes your rights regarding the use or disclosure of your protected health information that is subject to this authorization.

- You have the right to revoke this authorization, in writing, at any time by sending notification to the Privacy Officer for Superior Urgent Care. A revocation will prevent us from further use or disclosure of your protected health information, but it will not retract the uses or disclosures that have already been made pursuant to the authorization. Revocations will not be effective to the extent that we have taken action based on the authorization.
- The protected health information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- You have the right to refuse to sign this authorization.
- You have the right to inspect and copy the protected health information covered by this authorization.
- Superior Urgent Care will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I sign this Authorization, unless: (a) the treatment being provided is research-related and the PHI is to be used for that research; or (b) the health care the PHI is providing is being provided solely for the purpose of providing the PHI to a third-party.

1. I, _____, authorize **Superior Urgent Care**, to disclose protected health information to: _____ (Name of entity receiving information) Fax: _____

   OR mail: _____

   the following protected health information: _____ for dates of service: _____

   regarding (conditions treated) _____

   The protected health information covered by this authorization may be used for the following purposes: _____

2. This authorization will remain effective until _____ (specify date for authorization to expire)

   By signing below, I acknowledge that I have read and understand my rights relating to this authorization for the use or disclosure of my protected health information.

_____ Signature of Individual or Personal Representative Date:_____

FAX COMPLETED FORM TO (817) 796-1422. ALLOW UP TO 2 WEEKS.