

DR. J EXPRESS CARE

Urgent Care Institute of Abilene, LLC
HIPAA Privacy Policy

SIGNING THIS FORM AUTHORIZES **DR. J EXPRESS CARE**
TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION DESCRIBED BELOW.

PATIENT'S NAME:

MY PROTECT HEALTH INFORMATION MAY BE RELEASED TO THE FOLLOWING PERSON(S):

NAME/RELATIONSHIP

PHONE

NAME/RELATIONSHIP

PHONE

NAME/RELATIONSHIP

PHONE

NAME/RELATIONSHIP

PHONE

REASON/PURPOSE FOR THIS RELEASE OF INFORMATION:

PATIENT CARE

OTHER

THIS AUTHORIZATION SHALL BE EFFECTIVE UNTIL:

FURTHER NOTICE

OTHER

Do we have permission to :

Leave a message on your answering machine?

Yes

No

Leave a message at your place of employment?

Yes

No

Discuss you medical information with any member
of your household?

Yes

No

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING
AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO:

Dr. J Express Care North

Dr. J EXPRESS CARE 1634 STATE HWY 351 ABILENE, TEXAS 79601

Dr. J Express Care South

Dr. J EXPRESS CARE 4009 RIDGEMONT ABILENE, TEXAS 79606

NOTICE OF HIPAA PRIVACY PRACTICES

I HAVE REVIEWED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH
EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I
UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE OF PATIENT/REPRESENTATIVE

DATE

RELATIONSHIP TO PATIENT