Patient Consent for Disclosure
of Protected Health Information

I have the right to review the Notice of Privacy Practices prior to signing this consent. **North Georgia Urgent Care** reserves the right to revise its Notice of Privacy Practices at any time.

I acknowledge and agree that **North Georgia Urgent Care** and/or vendor including billing and/or collection companies may contact me on the numbers listed below. With this consent, **NGUC** may share my Personal Health Information (PHI) in the following methods:

Leave a message on home phone? Yes / No Phone number _____

Leave a message on cell phone? Yes / No Cell Phone Number _____

Send an email? Yes / No Email Address _____

I authorize North Georgia Urgent Care to release/ disclose my PHI including lab and test results, diagnosis and treatments to the following individuals:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of patient or legal Guardian Date

_____

Print Patient's Name