ERgent Med
IMMEDIATE AND PRIMARY CARE

# HIPAA Authorization Form

**HIPAA authorization grants permission from the patient or the patient's legal guardian to share personal medical information.**

**Patient Name: _____ Patient DOB: _____**

**Street Address: _____ City: _____ State: _____ Zip: _____**

**I, _____ hereby authorize ERgent Med and/ or any medical facility to release any and all medical**
Print Patient or Legal Guardian's Name

**information and test results that pertain to me, to the following individual(s):**

**Name: _____ Phone: _____ Relationship to patient: _____**

**Name: _____ Phone: _____ Relationship to patient: _____**

**Name: _____ Phone: _____ Relationship to patient: _____**

I authorize ERgent Med or the medical facility or employees to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

This authorization will remain in effect from _____ until I cancel or revoke the authorization.
Today's Date

I understand that I may revoke / cancel this authorization by notifying ERgent Med in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____
Signature of Patient Date

OR, if applicable:

_____ _____ _____
Signature of legal guardian or personal representative of patient's estate Date Description of authority to act for the patient

_____ _____ _____
Name of Witness Witness's Signature Date