

**NOVA MEDICAL GROUP/NOVA URGENT CARE  
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
Print Patient full name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Birth date

\_\_\_\_\_  
Street address

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City/State/Zip

(\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_  
Home phone number

I, \_\_\_\_\_, do hereby authorize **Nova Medical & Urgent Care Center, Inc.** to release:  
patient name

_____ Discharge Summary	_____ Pathology Reports	_____ Emergency Reports
_____ History & Physical	_____ Laboratory Reports	_____ Entire Chart
_____ Progress Notes	_____ Radiology Reports	_____ Other _____
_____ Operative Notes	_____ ECG/EEG/Cardiac Cath	_____

**ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO  
COMPLY WITH YOUR REQUEST (please check one)**

\_\_\_\_\_ I do \_\_\_\_\_ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

RELEASE INFORMATION TO: \_\_\_\_\_  
Name of Company/Agency/facility/Person

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

**PURPOSE OF DISCLOSURE:**

\_\_\_\_ Referral to specialist    \_\_\_\_ Insurance    \_\_\_\_ Workers Comp    \_\_\_\_ Change of Doctor/Provider  
\_\_\_\_ Legal Investigation    \_\_\_\_ Disability determination    \_\_\_\_ Self    \_\_\_\_ Continuing care  
Other (please specify) \_\_\_\_\_

**Please provide the best telephone number in the event we need to contact you (home, work or cell)**  
(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

\_\_\_\_\_  
**Signature of individual or guardian or  
Personal Representative of patient's estate**

\_\_\_\_\_  
**Date**

NOTE: There is a fee for any copies or transfers of your medical records. The charges are as follows; \$10.00 search and handling fee, plus \$0.50 cents per page for the first 50 pages and \$0.25 cents per page thereafter, and any postage fees.