

Priority Urgent Care-Privacy Notice

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given the opportunity to review Privacy Practices of Priority Urgent Care.

I hereby authorize Priority Urgent Care to disclose my Protected Health Information (PHI) to my Primary Care Physician (PCP) and/or the following people:

Primary Care Physician (PCP):

Phone Number:

Fax Number:

Name:

Relationship:

Name:

Relationship:

Print Patient Name :

Patient or Representative Signature :

Name of representative signing:

Date: