Milford Regional Physician Group
The Benchmark for Quality Care

# Urgent Care Authorization for Release of Information

I, _____, do hereby authorize the disclosure of my medical record information from Milford Regional Physician Group, Inc. to my Primary Care Physician, as identified below, to include each of the following (check boxes to authorize):

☐ Domestic Violence Counseling

☐ Sexual Assault Counseling

☐ HIV Test Results

☐ Sexually Transmitted Diseases

☐ Genetic Screening Test Results

PCP Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Patient Name: _____ DOB: _____

(Print)

Signature: _____ Date: _____

(Patient/Parent/Legal Representative)

1/2018