Velocity Care
Urgent Treatment Center

ALTERNATIVE CONTACTS AND TREATMENT FORM

We at Velocity Care Urgent Treatment Center take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____ I do **not** authorize anyone to receive information regarding my medical care.
_____ I authorize my physician and the employees of this clinic to speak with:

1. Person:_____ Relationship:_____
   Phone number(s):_____
   ☐ appointments ☐ account/bill ☐ lab results ☐ test results ☐ medical care ☐ treatment

2. Person:_____ Relationship:_____
   Phone number(s):_____
   ☐ appointments ☐ account/bill ☐ lab results ☐ test results ☐ medical care ☐ treatment

Alternate means of contacting me are:

Cell Phone: _____ My Fax number: _____

My answering machine/voicemail/pager: _____

Email: _____

Other: _____

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Velocity Care Office Manager.

I agree that should I desire to revoke this authorization, I will give written notice.

_____ Patient Signature

_____ Parent/Guardian Signature

_____ Witness Signature

_____ Date

_____ Time