C.O.R.E. Medical Clinic, Inc.
EMERGENCY CONTACT RELEASE OF INFORMATION

PATIENT NAME: ____________________ PT ID#: __________

ADDRESS: ____________________

CITY: ____________________ STATE ______ ZIP __________

PHONE #: Home: Work: Message

IN CASE OF EMERGENCY, PLEASE CONTACT:

CONTACT NAME: ____________________ RELATIONSHIP __________

ADDRESS: ____________________

CITY: ____________________ STATE ______ ZIP __________

PHONE #: Home: Work: Message

I, ____________________ hereby authorize C.O.R.E. Medical Clinic, Inc.

to contact the above named person in the event of an emergency.

This consent is subject to revocation in writing by the undersigned at any time except to the extent that action has been taken in reliance hereon. Revocation shall be effective upon actual receipt of written revocation signed by the patient. If release is not earlier revoked, it shall, without express revocation, terminate on:

(Date 1 year from today OR Condition) ____________________

____________________ ____________________

Patient Signature Date

WARNING TO PERSON RECEIVING INFORMATION: *This information has been disclosed to you from records protected under federal or state law and cannot be disclosed without your written authorization unless otherwise provided. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. All HIV test information released must be labeled with a statement that: "This information may not be disclosed to anyone without the specific written authorization of the individual." A general authorization for the release of medical or other information is not sufficient of this purpose.*

PENALTY: Not more than $500 fine for the first offense. Not more than $5000 fine for subsequent offense(s).

TO REVOKE ANY PART OF THIS RELEASE REVOKES IT IN ITS ENTIRETY

Release Revoked by: ____________________ Date: ____________________

Patient Signature