



AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Date(s) of Service: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

- Continuing Medical Care
- Social Security/Disability
- Legal Purposes
- Military
- Personal Use
- Insurance
- School
- Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

- X-ray/CT images
- Lab/Pathology Reports
- FastERcare Record
- Discharge Summary
- Face Sheet

FastERcare may release the above information to (specify name/title of individual or the name of the organization to which records are to be released):

Individual or Organization Name Phone Number

Address (Street/City/State/Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug and alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of test results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Signature of Patient or Legal Authorized Representative

Date Signed

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient