CITY DOC
URGENT CARE

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient's Name: _____Date of Service_____

Date of Birth: _____ Last 4 digits of SS#: _____

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

PATIENT INFORMATION IS NEEDED FOR:

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

INFORMATION TO BE RELEASED OR ACCESSED:

____ History & Physical ____ Consultation Report ____ Face Sheet
____ Lab Pathology Reports ____ X-ray Reports/Images Other:_____

The above information may be released to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address.)

_____

(Name of Individual and/or Organization, Doctor, Hospital, Attorney, Insurance Co. Requesting Records

Phone#_____ Fax# To Send Records To:_____

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 the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including the 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 certain circumstances such as for participation in research programs, or authorizations of the release of testing 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 retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law.

The authorization will expire One Hundred and Eighty (180) days from the date of my signature unless otherwise specified by date, event, or condition follows:

Date: _____ Signature: _____
Patient or Legal Authorized Representative

_____
Printed Name of Patient or Legal Authorized Representative

_____ _____
Relationship to Patient For department use: MRN/Acct #

PLEASE FAX FORM BACK TO (214) 871-7020