Medical Records Request / Release Authorization

FastMed

Patient Name: _____
Last *First* *Middle Initial*

Mailing Address: _____
Number and Street *Unit/Apt* *City/State/Zip*

Primary Phone: _____ Date of Birth: _____ SSN: _____

I hereby authorize:

_____
Medical Record Holder

_____
Address Number and Street *City/State/Zip*

_____ _____
Telephone *Fax*

To release medical information on me including:

Documents needed: ☐ Entire Record ☐ Radiology Reports ☐ Progress Notes ☐ Other _____

Dates of Service needed: ☐ All ☐ Last visit only ☐ Records dated from _____ to _____

To the following:

_____
Medical Record Requestor

_____
Address Number and Street *City/State/Zip*

_____ _____
Telephone *Fax*

For the purpose of:

☐ Continued Care ☐ Research ☐ Insurance ☐ Legal ☐ Disability ☐ Personal

☐ Other _____

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this authorization.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this authorization. I understand that I am under no obligation to sign this authorization, and that my ability to obtain services from FastMed will not depend in any way on whether I sign this authorization. I understand that I have a right to receive a copy of this Authorization. I understand that FastMed may charge me or the Recipient a reasonable, cost-based fee for such records.

I understand that state and federal law may prohibit the recipient from re-disclosing information provided pursuant to this Authorization, but that FastMed has no control over the recipient and cannot guarantee that the recipient will not re-disclose the information. I hereby release FastMed from any and all liability related to (i) it's reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

By signing below, I authorize _____ and its representatives to release the information about me described above.

Patient Signature: _____ Date: _____

If the patient is (i) a minor, the patient's parent or legal guardian should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself/herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below.

Signature of Representative: _____ Date: _____

Name of Representative: _____ Relationship to Patient: _____

For Internal FastMed use only – Release

Patient ID Verified by: *Photo ID* *Other* _____

Patient MRN: _____ *# of pages released* _____

_____
Team member releasing records – printed name and signature *Date*

For Internal FastMed use only – Request

Date Sent: _____ *Sent by:* _____

Date rcvd: _____ *Pages rcvd:* _____

Date records scanned to chart: _____