Patient Name: ________________________________

Medical Record Number: _______________________

Date of Birth: _________________________________

Authorization for Release of Protected Health Information

I authorize and request FastMed Urgent Care to release the following protected health information (PHI) from the medical records of the patient listed above to: ____

Date(s) of Service authorized to be released: _______________________________

Method of Delivery for Disclosure

□To be mailed to the following address: ____

____

□ Fax to medical provider: ________________________

□ By electronic access to medical and claims information

□ Through oral communications

Information to be Included in Disclosure:

□ Summary Health Information (Clinic Notes, Laboratory Reports, Radiology Reports, Clinic Notes)

□ Demographic Information (Name, Date of Birth, Medical Record Number, Address, Phone number)

□ Laboratory Reports □ Radiology Reports □ Immunization Records

□ Clinic Provider Notes □ Other: ____

□Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis and treatment to date

□ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse

Information to be Disclosed will be for the Following Purpose:

□ To a Non-Referring MD for Continued Care

□ Personal Use □ Legal Reasons □ Other: _________________________

This authorization shall cover FastMed Urgent Care and all of their respective employees, workforce, and business associates. This authorization may be revoked at any time, provided that the revocation is executed in writing to the FastMed Chief Compliance Officer at 935 Shotwell Road Ste 108, Clayton, NC 27520. Revocation will not affect any disclosures acting upon by this disclosure and prior to request for revocation. Information disclosed pursuant to this authorization may be re-disclosed and is no longer protected by federal and state privacy rules. Authorization of disclosure of the above information is voluntary and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on _______________________ (date or event). **If I failed to provide an expiration date, the authorization will expire one (1) year from the date of signature.**

Signature of Patient or Patient Representative*: ________________________________Date_________________

*If signature is for a patient representative, please describe relationship to patient__________________________