TGH URGENT CARE powered by FAST TRACK

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____

I authorize and request the following organization to release information as stated below from the patient health information record:

Information Requested FROM:

☐ TGH Urgent Care powered by Fast Track

Or

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

Information Released TO:

☐ Self

☐ TGH Urgent Care powered by Fast Track

Fax Number: 813-749-8370

Or

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

Information to be Released:

- ☐ Diagnostic Imaging ☐ All ☐ From Date(s): _____
- ☐ Lab Results ☐ All ☐ From Date(s): _____
- ☐ Progress Notes ☐ All ☐ From Date(s): _____
- ☐ Other, specify: _____
- ☐ Entire Medical Record. No limitations placed on dates, history of illness or diagnostic and therapeutic information for treatment for alcohol and drug abuse as protected by Federal Regulation 42CFR, Part II; psychiatric/psychological information and HIV/AIDS related information including testing per FS 90.503, 381.004, and 394.459.

Authorization for General Release of Information:

I understand that I have the right to revoke this authorization at any time. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to assure treatment or payment. I understand I can cancel this authorization at any time in writing to any TGH Urgent Care powered by Fast Track location or by mail to 3301 W Gandy Blvd Tampa, FL 33611. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____

Patient Signature or Signature of Authorized Representative of Patient **Date**