Please contact us directly via email: ***Clientservices@fasttrackurgentcare.com*** *or use* ***fasttrackurgentcare.com/onmyway*** *check in to expedite the visit.*
Our offices are available 8 AM – 8PM daily.

Emergency Medical Condition (EMC/MVA) Request

☐**Westchase**
11969 Sheldon Rd.

☐**South Tampa**
3301 W. Gandy Blvd.

☐**Carrollwood**
4505 Gunn Hwy

☐**Wesley Chapel**
5504 Gateway Blvd.

☐**Brandon**
799 W. Lumsden Rd.

☐**Tyrone**
3251 66th St. N.

☐**Seminole**
7601 Seminole Blvd.

☐**Sun City Center**
16521 US Hwy 301 S.

☐**Fish Hawk**
5464 Lithia Pinecrest Rd.

☐**Apollo Beach**
6182 N. US Hwy 41

☐**Riverview**
11406 US Hwy 301 S.

☐**Tarpon Springs**
40545 US 19th N

☐**Downtown at the Heights**
303 W. Palm Ave.

☐**Downtown on Water Street**
564 Channelside Dr.

☐**Trinity at Starkey Ranch**
13531 State Rd. 54

☐**4th Street**
4949 4th Street N.

EMC: ☐ or MVA: ☐

Patient Name:___________________________________

Patient Date of Birth:___________________

Insurance Carrier: ________________________________

Medical Claim #:________________________

Patient Phone Number: ___________________________

Date of Accident:__________________________

Referring Office/Organization

Were you referred to us? ☐Yes ☐No

If **YES**, please provide the following information:

Office/Organization Name: _______________________

Phone Number: (______) __________________________

Fax Number: (______) ____________________________

Designated Representative Name:
____

Attorney Information

Is there an attorney assigned to the case? ☐Yes ☐No

If **YES**, please provide the following information:

Law Office Name: _________________________________

Attorney Name: __________________________________

Phone Number: (______) ____________________________

Fax Number: (______) _____________________________

Requested Services

X-ray

☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Hips/Pelvis
☐ SI Joints
☐ Knee R / L
☐ Ankle R / L
☐ Foot R / L
☐ Additional Imaging:
____

Medication Management

☐ NSAIDs
☐ Muscle Relaxers
☐ Topical Analgesics
☐ Other: ____________

Request for Medical Records

This signed form authorizes the release of medical records information necessary for billing or continuity of care. If there are specific records needed for this patient, please check information to be released:

☐ **All Records**

☐ If specific item(s) requested, please specify: ___________________________________

Preferred method to receive requested records:

☐ Secure Fax

☐ Mail

Patient (or Authorized Representative) Signature: ____Date: ______________