EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Patient Authorization to Release Medical Information

Patient Name: _____ **Date Of Birth:** ____/____/____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below Urgent Care of Texas. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

I authorize the disclosure of the authorized information from:

Name: URGENT CARE OF TEXAS **Phone:** (817)472-7601 **Fax:** (817)472-7213

Address: 6407 S. Cooper St., #117, Arlington, TX 76001

Description of the information to be used or disclosed (check all that apply):
Records to be released for services from: ____/____/____ to ____/____/____

( )Doctor's Office Notes ( ) Entire Chart ( ) Diagnostic Studies ( ) Labs
( ) X-rays reports and films ( ) Other: _____

This information is to be released to:

Name: _____ **Phone:** _____ **Fax:** _____

Address: _____

I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") or infection of Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Urgent Care of Texas must receive the revocation in writing. The revocation must include:

- The patient's name and address
- The effective date of this authorization, and the recipients of medical release form according to this authorization
- The patient's desire to revoke this authorization, and
- The date of this revocation, and the patient's signature.

ALL Revocations must be sent to Urgent Care of Texas 651 N. Denton Tap Rd., #100, Coppell, TX 75019

This authorization shall expire One Year (365 days) from the date of my signature unless I revoke the authorization prior to that time. I understand Urgent Care of Texas may not condition treatment on my completion of this authorization form. I fully understand and accept the terms of this authorization.

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

_____ _____

Print name of Patient or Patient's Legal Representative **Legal Representative Relationship**