Authorization for the Use and Discloser of Protected Health Information

I hereby authorize Faster Care to use and disclose my Protected Health Information as described below.

I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name (Last, First):____

Address: _________________________________ Telephone Number: ______________________

Last four of SSN: ________________________ Date of Birth:_____________________________

Name of Person/facility Authorized to Receive the Information:

Name (Last, First): ____

Address: ___________________________________ Telephone Number: ____________________

City, State, and Zip Code: ___________________________________ Fax Number: ___________________

Purpose of Disclosure: ____

Dates of Treatment: ___ All **OR** Specific date range: ___________ to ____________

Information to be Used/Disclosed – CHECK all that apply:

__Entire Medical Record __ Billing Summary **Other:** _________________

__ Progress Notes __Radiology Reports

__ Laboratory Report __Radiology Imaging Disks

I must Separately authorize the following if desired – CHECK all that apply:

__Alcohol abuse/treatment record __Mental Health Treatment

__Drug abuse/treatment record __STD/HIV Status/Treatment

Requested Method of Deliver CIRCLE all that apply Pick up Fax Verbal Mail (to address on this form)

Expiration Date : 90 days from Signature date OR Specific Date: ________________________

- You may ask for a copy of this authorization.
- This authorization will expire on date you indicated above. You may revoke this authorization at any time by submitting a written request to Faster Care. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You will be responsible for requesting to update this form upon designated expiration date.

Signature of patient/legally qualified Representative: _____________________________ **Date:** _____________

Print name of patient/ legally qualified representative:_________________________

****Legal documentation must be obtained to released upon request of legal representative.****

Faster Care 3440 Declaration Blvd. Sumter, SC 29154

Phone : 803-905-3278

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