Lake Worth Minor Emergency Center
6302 Jacksboro Hwy Suite A
Fort Worth, TX 76135
(817) 237-8273
Fax: (817) 237-0374

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

NAME: _____ _____ _____
LAST FIRST M.I.

D.O.B. ____/____/____ **AGE:** _____ **SS#:** _____ **Phone Number:** _____

Address/City /State/Zip: _____

I, _____, hereby authorize
LWMEC, to ☐ **REQUEST** ☐ **SEND** the following information by mail, fax or orally to:

Physician/Facility/ Receipt Name: _____

Address/City /State/Zip: _____

Phone Number: _____ Fax Number: _____

For the purpose of: ☐ Continue Medical Care ☐ Personal Use ☐ School ☐ Insurance ☐ Legal Purposes ☐ Other: _____

My authorization extends only to those data/elements/documents marked below:

☐ All Records
☐ Statements of Charges or Payments
☐ AIDS or HIV Information
☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
☐ Mental Health and/or Alcohol and Drug Abuse Treatment
☐ Progress Notes
☐ Discharge Summary
☐ Consultation Reports
☐ Hepatitis Information
☐ Photographs, Videotapes, Digital, or other Images

☐ **Record of visit for a specific date(s). Specific dates include or are limited to:**

_____
_____
_____

☐ **Other (must be specific):**

_____
_____
_____

This authorization is given freely with the understanding that:
1. Any and all records, whether written ,oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Lake Worth Minor Emergency, and its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclose by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization

_____ _____
Witness Date

☐ **Jerry Davis, D.O.** ☐ **Tamara Hanby, D.O.** ☐ **Scott Hughes, D.O.**