AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Last Name:	Patient's First Name:
Date of Birth:	Phone Number:
Address:	City, State, Zip

☐I authorize CapRock Urgent Care, LLC / Caprock Physicians PA, LLC to RELEASE information to:
Name:
_____
Address:_____
Office Phone / Fax: _____

☐I authorize CapRock Urgent Care LLC / Caprock Physicians PA, LLC to OBTAIN information from:
Name:
_____
Address:_____
Office Phone / Fax: _____

I hereby authorize the use or disclosure of Protected Health Information as described below for the following DATE(s) of SERVICE:

☐ Complete Health Record ☐ Assessments ☐ History / Physical Exam ☐ Progress Notes ☐ Discharge Summary	☐ Treatment Plans ☐ Treatment Summary ☐ Diagnostic Impression	☐ Laboratory Report ☐ CT Report ☐ CT Images ☐ X-Ray Report ☐ X-Ray Images

Purpose of Disclosure: ☐ Healthcare ☐ Insurance ☐ Personal ☐ Attorney/Litigation ☐ District Attorney
☐ Other:

One-Time Use / Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. Authorization expires:
☐ When the requested information has been sent / received
☐ 90 days from this date ☐ Other:

Periodic Use / Disclosure: I authorize the periodic use or disclosure of the information described above to the person /provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document

Authorization Expiration:
☐ When I am no longer receiving services from the provider/facility/organization listed above.
☐ One year from this date ☐ Other:

I UNDERSTAND that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to CapRock Emergency LLC / Caprock Emergency Physicians PA, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of the facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be-disclosed
- If the authorized information is protected by the Federal Confidentiality Rules 42FCR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV / AIDS related information requires additional information
- Communicable diseases including any Texas Notifiable Conditions and other communicable diseases which may pose a threat to the general public, required by TDSHS, CDC or any regulatory agency may be released with or without my permission.
- If the medical record information is not sent to another care provider, there may be a change for the requested records.

Signatures: I have read the above and authorize the disclosure of the Protected Health Information as stated:

Signature of Patient (or Patient's Representative):_____Date:_____
Printed Name of Patient (or Patient's Representative):

If you are the Patient Representative, check the scope of your authority to act on patient's behalf:
☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor or Personal Representative ☐ Other:

CapRock Urgent Care LLC / Caprock Physicians PA, LLC USE ONLY

☐*Copy of Identification Attached and Verified – Additional ID may be required at the request of the facility.*
(Picture Identification MUST be provided prior to "Release of Information".)*
Signature of Person Releasing Information: