THE UNIVERSITY OF TEXAS AT AUSTIN
FORTY ACRES PHARMACY

Authorization for Release of Prescription Records

I authorize the release of protected health information as directed below:

LAST NAME (PLEASE PRINT)	FIRST NAME (PLEASE PRINT)	DATE OF BIRTH
EMAIL ADDRESS	UTEID	PHONE NUMBER

PRESCRIPTION RECORDS BEGINNING DATE: _____

ENDING DATE: _____

NOTE: If specific dates to be released are not indicated, all records will be released.

Release Records From:

Forty Acres Pharmacy
100 W Dean Keeton
Austin, TX 78712
Ph (512) 471-1824
Fax (512) 475-8218

Release Records To:

☐ if same as above

OR:

_____
NAME / ORGANIZATION

_____
ADDRESS

_____
CITY STATE ZIP CODE

_____
PHONE FAX

☐ Please call when my records are ready for pick-up

☐ Please fax my records to **fax #**_____

_____ _____
SIGNATURE OF PATIENT (OR IF LEGAL REPRESENTATIVE-STATE AUTHORITY TO ACT) DATE

PLEASE FAX COMPLETED FORM ALONG WITH A COPY OF YOUR PHOTO ID TO 512-475-8218 OR EMAIL COMPLETED FORM AND PHOTO ID TO info@fortyacrespharmacy.com