AUTHORIZATION TO RELEASE MEDICAL RECORDS

Printed Name of Patient (first, middle, last name)

Birthdate (mm/dd/yyyy)

Address (Street Address, City, State, Zip Code)

Phone Number

E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)

Address (Street Address, City, State, Zip Code)

Phone Number

E-mail

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

Send Medical Records to:

Street Address

City

State

Zip Code

Phone Number

Fax Number

☐ To **release** my confidential information from:

☐ To **request** my confidential from:

Person/Organization to Receive Information

Street Address

City

State

Zip Code

Phone Number

Fax Number

☐ Pick up paper copies ☐ Email Records ☐ Mail Records ☐ Copies by fax

By providing my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

WellSpace Health — We see You.

The following health information that relates to service beginning from ____________ to ____________, may be released.

Please Initial:

_____Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.

_____Immunizations
_____Medication List
_____Patient Histories
_____Office Notes (except psychotherapy notes)
_____Test Results
_____Radiology Studies
_____Films
_____Referrals
_____Dental X-Rays
_____Case Management
_____Consults
_____Billing Records
_____Insurance Records
_____Records Sent by Other Health Care Providers
_____Other________________________

I further authorize the release of the following:

☐ Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis

☐ HIV-Related Treatment

☐ Mental Health Information or Psychological Conditions

☐ Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of **(please check box):**

☐ Change of Doctor
☐ Individual Request
☐ Specialist Referral
☐ Workers Compensation
☐ Insurance Purposes
☐ Continued Treatment
☐ Legal Investigation
☐ Other: ________________

For Patients/Clients:

- I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.
- A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time.
- I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.
- I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below.
- I am entitled to a copy of this authorization.
- This authorization is valid until________________________or for 12 months following the date of my signature shown below.

Signature of Patient or Personal Representative:	Date:	Description of Personal Representative's Authority: