West Wilson Family Practice Center, P.C.

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Medical Records Release Authorization

I hereby authorize ______________________ (releasing party)
(Phone #)________________ to release or disclose my medical records as described below. To the below named person or organization.

Mail records to:______________________
____

Pick up records______
Fax______________

Patient's Name ________________________
&Address: ________________________
Please print ________________________

Patient's SS #____________
Patients d.o.b. ____________

Phone # for patient if there are questions about release ______________________
Purpose for disclosure____

A. Only records generated by clinic. Initial: __________
B. Only a portion of records. List dates of treatment or specific report wanted.________________ Initial : __________
C. All records at this facility (Films Must Be Obtained from Radiology Department) Initial: ____________

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4. If you DO NOT WANT certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

- I authorize the clinic/ physician listed in Section 1 and any employees and/ or agents to release the information specified to the organization, agency, or individual named on this request with the exception of:

Initials ____ Substance abuse, if any
Initials ____ Psychological or psychiatric conditions, if any
Initials ______ AIDS/ HIV/ STD's, if any

- I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the clinic/ physician listed in Section 1 and any employees and/ or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Record Reproductions at the address shown above.
- I understand that I am not required to sign this Authorization. The clinic/ physician listed in Section 1 and any employees and/ or agents will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provide this Authorization.
- I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the ability of the clinic/ physician listed in Section 1 and any employees and/ or agents to use or disclose my information for treatment, payment or health care operations, or as otherwise permitted by law.

Patient or authorized Representative's Signature________________________________ Date____________

Relationship to patient________________ Witness signature ____________________ Date____________