# West Wilson Family Practice Center, P.C.

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## Medical Records Release Authorization

I hereby authorize West Wilson Family Practice to release or disclose my medical records as described below. To the below named person or organization.

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Mail records to:_____ Pick up records_____
_____ Fax_____

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Patient's Name _____ Patient's SS #_____
&Address: _____ Patients d.o.b. _____
Please print _____

Phone # for patient if there are questions about release _____
Purpose for disclosure_____

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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_____