Whole Life Health Care - Family Practice

Medical Records Authorization to Release or Request Healthcare Information

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Phone: 603-431-6677 Fax: 603-610-2232
www.mywholelifehealthcare.com

Patient Name____ Date of Birth___________________________

Office or Person **Releasing** Medical Record Information:

____Phone__________________Fax_________________

Address____

Office or Person to **Receive** Medical Record Information:

____Phone__________________Fax_________________

Address____

Medical Record Information will be (please check one):

☐ Picked up by Patient

☐ Please mail to receiving office/person
*(*please note you may be charged a shipping and handling fee)*

Information to be released (please check all that apply):

☐ Complete Medical Record
☐ Last Annual Exam and Pap Test
☐ Immunization Records
☐ Treatment Records / Progress Notes
☐ Laboratory Tests
☐ Diagnostic Tests (X-Rays, CT Scans, MRIs)
☐ Other: ____

I understand that the information I have agreed to release may include but is not limited to sensitive information such as: sexually transmitted disease, AIDS, HIV, behavioral or mental health services, alcohol drug abuse treatment, sexual preference, counseling/family problems. I agree to its release. If you DO NOT WANT this information released please specify what information should NOT be released:

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To help improve our patient care, please let us know the reason you are requesting these medical records:

☐ Personal Copy
☐ Second Opinion
☐ Sharing Care with Specialist
☐ Moving out of area
☐ Dissatisfied with Provider
☐ Transferring / Other, please describe:_________________________
☐ Insurance Purposes
☐ Legal Purposes

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I understand that:

~I can see and copy the health information described above.
~I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.
~Under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
~I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.
~ Consent expires one year from date signed

Patient / Legal Guardian Signature____Date_______________

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