Woodstock Family Medicine

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

By **initialing** the spaces below, I, _____ DOB; _____ hereby authorize, **Woodstock Family Medicine** to release information **to**: _____ obtain information **from**: _____ **(or)** exchange information verbally **with**: _____

Name: _____Phone: _____

Street: _____Fax: _____

City: _____State_____ Zip _____

The information will be used on my behalf for the following purpose(s): _____

_____

By **initialing** the spaces below, I specifically authorize the release of the following medical records if they exist.

____ Medical records needed for continuity of care
____ Clinic office chart notes
____ Emergency and Urgent care records
____ Laboratory reports
____ Diagnostic imaging reports
____ Medication records
____ Billing statements
____ Gynecologic history, exams and Pap smears results
____ Contraception records
____ Physical therapy records
____ All Hospital records
____ Pathology reports
____ Most recent 5 years
____ Other_____

____ Please send the **entire medical record** (all the above information, plus any initialed below. The undersigned patient agrees this record may be voluminous and agrees to pay all reasonable fees associated with providing this information.

____ **HIV/AIDS** related records (***must be initialed*** *to be included in other document*.)
____ **Mental Health** information which includes depression (***must be initialed*** *to be included in other documents*)
____ **Genetic** testing information (***must be initialed*** *to be included in other documents*)
____ **Drug/Alcohol** diagnosis, treatment or referral information (*Federal Regulations, 42CRF Part 2, requires a description of how much and what kind of information is to be disclosed).* _____
(be specific)

____ This authorization is limited to the following **treatment**: _____
(be specific)

____ This authorization is limited to **workers' compensation** claim for injuries of (date). _____
(be specific)

____ This authorization is limited to the following **time period**: _____
(be specific)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. These records **may / may not** be sent by fax.

_____ _____
Date Signature of patient or person authorized by law