FamilyWellnessMD
Healthy Families. Healthy Kids.

Medical Records Release Form

Patient Name: ______________________________ Date of Birth: ____________________

I hereby authorize Family Wellness MD to release to the following person(s) and/or entity(ies). (Please identify by name or general description and provide address/fax number, if known):

Name: ____

Address: ______________________________City: ______________________ State: _________
Zip: _________

Fax Number:______________________

The following protected health information regarding the patient (Please mark appropriate box(es)):
□ Complete Medical Record □ Labs only □ Progress Notes only
□ Other (Please specify clearly): ____

For the following dates of service: Start Date: __________________ End Date: __________________

<u>Unless you state otherwise</u>, this authorization includes the release of all medical records, including but not limited to, paper/electronic records, x-rays, films and any information regarding treatment or referral for substance abuse, including drugs and alcohol, except as otherwise noted below.

<u>Unless you state otherwise by marking one or both boxes below</u>, this authorization **includes** the release of records which may include **(i) HIV/AIDS** information and/or **(ii) privileged mental health communications** between the patient and a mental healthcare provider, and you affirmatively waive any protections from disclosure that might otherwise apply. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** information and/or **privileged mental health communications** can be authorized only by the patient or an individual legally authorized to make a living patient's healthcare decisions, including a legal guardian, healthcare agent, or parent of a minor.

□ I object to the release of **HIV/AIDS** information
□ I object to the release of any **privileged mental health communications**

The purpose of the requested disclosure is: ____________________________________

I understand that my/the patient's treatment at Family Wellness MD will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. Revoke by submitting a written request to Family Wellness MD identified above.

This authorization for the release of protected health information shall remain in effect until the earlier of any either:
(a) ____________ **(include a specific expiration date); (b)** the date I revoke this authorization in writing; or **(c)** three (3) years from the date I signed this authorization. If authorization is signed on behalf of a minor, it will expire when the minor turns 18, marries, or becomes emancipated.

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By signing this authorization, you affirmatively represent that: (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his/her healthcare decisions, including the release of medical records. You understand the potential that medical records disclosed in whatever form and/or means provided may be subject to re-disclosure by the recipient and may no longer be subject to the protections under the federal privacy laws and regulations. You further understand that you may receive electronic health information that may not be encrypted or password protected and that you are responsible for taking precautions to protect and store the data in a secure manner. By choosing to receive your health information electronically, you acknowledge and accept the risk of doing so. You hereby release the Family Wellness MD and their agents/employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of medical records and information you have authorized above.

Signature of Patient or Legally Authorized Representative	Signature Date