

# Winchester Family Practice, P.C.

*Shyama Rosenfeld, MD*  
*Vicken Kalbian, MD*  
*Jeffrey Harris, MD*

*Krista Schofield, PA-C*  
*Whitney Simmons, PA-C*  
*Sandra Meisinger, NP*

## MEDICAL RECORD RELEASE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize Winchester Family Practice, P.C. to disclose the above named individual's health information as described below.

This information may be disclosed to and used by the following individual or organization:

Facility/Doctor/Hospital/Name \_\_\_\_\_

Full Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

For the purpose of:

### MEDICAL RECORDS NEEDED:

<input type="checkbox"/> Most recent History & Physical	<input type="checkbox"/> Most recent Progress Note/Office Visit
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Medication List
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Entire Record
<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> Other

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do in writing and present my written revocation to the Office Manager. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Signature of Patient or Legal Representative

Date of Request