Winchester Family Practice, P.C.

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MEDICAL RECORD RELEASE FORM

Please release the medical records for:

Name: _____ Date of Birth: _____

Facility/Doctor/Hospital Name _____
_____

Full Address: _____
_____

Phone: _____ Fax: _____

I authorize Winchester Family Practice to obtain my medical records as described below for the purpose of:
_____

MEDICAL RECORDS NEEDED:

____ Most recent History & Physical
____ Immunization Record
____ Lab Results
____ X-Ray Reports
____ Most recent Progress Note/Office Visit
____ Medication List
____ Entire Record
____ 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 low 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