West University Wellness

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Dr. Caroline Long
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Authorization for Medical Release

☐ I authorize that my medical records, x-rays, and any other films be released to the offices of West University Wellness.

☐ I voluntarily consent to authorize my medical records release from the offices of West University Wellness to:

_____

Name of place records will be released to/from (printed)

_____

Phone & Fax (printed)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information for the dates of service:

_____

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the_____day of_____, 20___.
☐ Until the Provider fulfills this request.
☐ Until the following event occurs:_____

Re-disclosure: I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

_____

Patient Name & DOB (printed)

_____

Patient/Guardian/Legal Representative Signature

_____

Date