Whole Life Health Care
NEW DIRECTIONS IN FAMILY MEDICINE

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Authorization to Release and Disclose Medical Information

Instructions:

- **Purpose of Disclosure MUST be completed.**
- **If Transfer of Care is indicated, all future appointments will be cancelled.**
- **Patients are provided with 1 personal copy free of charge. All subsequent requests will incur a fee.**
- **We do not accept CD copy of records.**

PATIENT INFORMATION	NAME_____DOB_____ ADDRESS_____ CITY_____STATE_____ZIP_____PHONE_____
RELEASE MEDICAL RECORDS FROM	☐ WHOLE LIFE HEALTH CARE (as above) or ☐ NAME OF COMPANY _____ ADDRESS _____CITY _____ STATE _____ ZIP _____PHONE _____ FAX _____
RELEASE MEDICAL RECORDS TO	☐ WHOLE LIFE HEALTH CARE (as above) ☐ PATIENT/ PARENT/GUARDIAN: ☐ PICK UP OR ☐ MAIL/ FAX ☐ NAME OF COMPANY _____ ADDRESS _____CITY _____ STATE _____ ZIP _____PHONE _____ FAX _____
MEDICAL RECORDS TO RELEASE	☐ **MEDICAL RECORD ABSTRACT**: **Complete record for last 3 years, plus ALL imaging, colonoscopies, pathology, operative reports and immunizations on file.** ☐ IMMUNIZATION RECORDS ☐ LAST PHYSICAL EXAM ☐ LABORATORY RESULTS ☐ OTHER (specify record types) :_____
PURPOSE OF DISCLOSURE	☐ TRANSFERING CARE Reason:_____ ☐ SHARING CARE ☐ PERSONAL COPY ☐ INSURANCE/ DISABILITY ☐ LEGAL PURPOSES ☐ FOR SCHOOL ☐ OTHER : _____

I understand that the information I have agreed to release may include but is not limited to sensitive information such as: sexually transmitted disease, AIDS, HIV, behavioral or mental health services, alcohol drug abuse treatment, sexual preference, counseling/family problems. I agree to its release. If you DO NOT WANT this information released please specify what information should NOT be released:

_____

I understand that:
~I can see and copy the health information described above.
~I can refuse to sign this authorization and that my refusal will not affect payment, eligibility for benefits or my ability to obtain treatment.
~Under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
~I can revoke this authorization in writing to the address above at any time, but my revocation will not apply to information that has already been disclosed or used in response to this authorization.
~ Consent expires one year from date signed

Patient / Legal Guardian Signature_____**Date**_____