

1005 Mar Walt Dr.
Fort Walton Beach, FL 32547



WHITE-WILSON MEDICAL CENTER, P.A.

Patient ID # _____

Telephone #: _____

Internal Use Only:

Fax #: _____

Routine: _____

Stat: _____

Medical Records Release Form

I authorize White-Wilson Medical Center to release or obtain confidential health information about me by releasing/requesting a copy of my medical records, or a summary or narrative of my personal health information to/from the physician/person/facility/entity below.

Patient Name: _____ Date of Birth: _____ Telephone #: _____

Special Releases:

I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the remainder of my medical records.

Initials: _____ Date: _____

I consent to the release of any records related to treatment for Behavioral Health or Substance Abuse with the remainder of my records.

Initials: _____ Date: _____

The information you may release, subject to my signature on this release form, is as follows:

- Complete Records History and Physical Care Plan Immunizations
- Lab Reports Radiology Reports Pathology Reports Treatment Record
- Operative Reports Hospital Reports Medication Record
- Other (please specify) _____

1 Year 2 Years Entire Record

Release my protected health information to:

Request my protected health records from:

Name: _____

Name: _____

Address: _____

Address: _____

City/State/Zip Code: _____

City/State/Zip: _____

Mail Pick Up Fax Other (Specify): _____

Phone #: _____ Fax #: (Doctor's Only) _____ Phone #: _____ Fax #: (Doctor's Only) _____

I understand that:

1. I may refuse to sign this authorization as it is strictly voluntary, however, records cannot be released without authorization.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing. Prior releases of information remain covered under the authorization in place at the time they were released.
4. If records are released to an individual other than a health care provider or health plan that information may no longer be protected by federal privacy regulations.
5. I understand that there may be a fee for records released to an individual other than a health care provider.
6. I may request a copy of this form after it is signed and dated.

Patient's Signature: _____ Date: _____

(Required for all patients 18 years and older)

Signature of Parent/Legal Guardian: _____ Date: _____

(Required for all patients under 18 years of age unless otherwise allowed by law. If legal guardian is signing, appropriate documentation must accompany this form)

Records will be provided to another health care provider at no cost. There is a copy fee for release of medical records for the patient's personal use. Prepayment is required before records can be released.