WHITE-WILSON
MEDICAL CENTER, P.A.

1005 Mar Walt Dr.
Fort Walton Beach, FL 32547
Telephone #: _____
Fax #: _____

Patient ID # _____

Internal Use Only:
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 #: _____

Patient Address: _____

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:
Name: _____
Address: _____
City/State/Zip Code: _____
_____
___Mail ___Pick Up ___Fax
Phone#:_____Fax#:(Doctor's Only) _____

Request my protected health records from:
Name: _____
Address: _____
City/State/Zip: _____
_____
___Other (Specify): _____
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 healthcare provider at no cost. There is a copy fee for patient personal use.