wellward
Regenerative Medicine

Authorization for Release of Medical Records

PATIENT: **Records to be released to:**

_____ _____

(Printed name of Patient) (Name of Recipient or self)

_____ _____

(Social Security Number) (Address to be mailed to)

_____ _____

(Date of Birth) (City, State, Zip Code)

Authorizes: _____ to release my medical records

INFORMATION TO BE RELEASED:

_____ History & Physical	_____ Laboratory Reports	_____ Entire Record
_____ Progress Reports	_____ ER Record	_____ Other (specify:
_____ Surgical Reports	_____ Radiology Reports	_____

SHARING OF SPECIAL PROTECTED RECORDS: I authorize the sharing of information about: (CIRCLE RESPONSE)

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) YES NO

b. The diagnosis or treatment of drug and/or alcohol abuse YES NO

c. The treatment and/or consultation for mental health or psychiatric disorders YES NO

REASON FOR DISCLOSURE:

_____ Additional Medical Care	_____ Physician Change	_____ Personal
_____ Insurance Eligibility	_____ Legal Proceedings	_____ Other

If the person(s) and/or organizations(s) listed above are not health care providers, health plans, or healthcare clearinghouses, who must follow the Federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and your health information may be re-disclosed without obtaining your authorization. YOUR RIGHTS AND OBLIGATIONS WITH RESPECT TO THIS FORM: You are under no obligation to sign this form. You may withdraw this authorization by written notification. If you agree by signing this authorization, you must be provided a signed copy of this form if so requested. I have had an opportunity to review the contents of this authorization and my rights in relation to this form. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

_____	_____	_____
Patient/Guardian Printed Name	**Patient/Guardian Signature**	**Date**
_____	_____	_____
Witness Printed Name	**Witness Signature**	**Date**

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wellwardmed.com