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RELEASE OF MEDICAL RECORDS REQUEST

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. The Source Wellness Center does not offer reimbursement for records received.

Patient Name (Please Print): _____ Date of Birth: ___/___/___

(Address) _____ (Phone) _____

Physician and Clinic: _____

(Address) _____

(Phone) _____ (FAX) _____

***** Please release the following information: *****

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

- _____ All Medical Records Necessary for the Continuity of Care
_____ Labs and Diagnostic Imaging Only
_____ Other: _____

Patient Signature: _____ Date: ___/___/___

Parent/Guardian Signature (if applicable): _____ Date: ___/___/___

***** Confidential Information *****

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to The Source Wellness Center. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

_____ HIV/AIDS test results and related information, including high risk behavior documentation.

Patient Signature

_____ Drug/Alcohol diagnosis, treatment, or referral information.

Patient Signature

_____ Mental Health information.

Patient Signature

Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of the above information is to be disclosed. Please provide a description of this information:

***** Please mail or fax as soon as possible to: *****