# Wolfson Medical Center

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

## ☐ STAT PATIENT IN OFFICE NOW

**Patient Name:** ______________________________________________________________________

**SSN:** ____________________________________ **Date of Birth:** _____/_____/_____

• • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • •

**I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM:** ____________________________

________________________________________________________________________________

**Please provide contact information for provider. Failure to do so will delay the process in obtaining medical records.**

**Address:** ____________________________________________________________________

**Phone:** ________________________________________ **Fax:** __________________________________

**TO RELEASE RECORDS TO:** ____________________________________________________________

**Address:** ____________________________________________________________________

**Phone:** _______________________________ **Fax:** _________________________________

• • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • •

**(Check all applicable): All Records Laboratory/Pathology Records X-Ray/Radiology Records**

**Abstract/Summary Pharmacy Records Other:** ___________________

• • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • •

**Please initial if you wish any of the following not to be released.**

**Do not release information related to:**

**____Substance Abuse ____Psychiatric/ Mental Health ____HIV ___Other:** ____________

• • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • •

**The information may be used/disclosed for the following purpose:**

**To continue care For health insurance Other:** ____________________________

_______________________________________________ _________________________________________

**Signature of Patient** **Printed Name**

_______________________________________________

**Date**

**This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time. If records being to patient, there is a charge of .60 cents per page.**

**A copy of this paperwork is the same value of its original.**