WINFIELD
Family Medicine
Healthcare for every stage of life

PEDIATRICS • WOMEN'S HEALTH • ADULT MEDICINE • OB • MINOR SURGERY • PREVENTATIVE MEDICINE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ **Date of Birth:**_____
Telephone Number:_____

I hereby authorize: (Facility name, address and phone number)

_____
Name of Facility

_____
Address

_____
Phone Number **Fax Number**

To release designated medical records to:

_____
Name of Facility

_____
Address

_____
Phone Number **Fax Number**

Information to be released:

____The entire medical records____(exclude documents relating to sexually transmitted disease, Aids, HIV, behavioral or mental health services and alcohol and drug abuse)
____Lab reports
____X-ray reports
____Consultation notes
____Test results (please specifiy if not requesting all tests)_____
____Other (specifiy)_____
_____

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Relationship of Representative

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