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AUTHORIZATION FOR OBTAINING MEDICAL RECORDS

I, _____, hereby request that you:
(please print)

Name of Facility/Doctor: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax Number: _____

My health being at issue, please release:

All my medical or psychiatric records

Admission History, Discharge Summary, lab/test results, and consults from
_____ Hospitalization.

The following only: _____

To: G.R. Wurster, M.D.

Judy K. Martin, M.D.

John L'Ecuyer, M.D.

Zachary Hugo, M.D.

Richard Brewington, M.D.

Reason for releasing my records: Continuity of care

(Be specific): _____

I understand that my medical records may include HIV, psychiatric, alcohol or drug abuse information. I also understand that I may revoke this consent by written request to this office at any time except to the extent that action already has been taken in reliance on it. This authorization expires automatically in one year. I understand that if the person or entity receiving this information is not a health plan or health care provider covered by federal privacy regulations the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment, or eligibility for benefits.

Signature of Patient: _____

Date: _____

Date of Birth: _____

Signature of Parent/Guardian (if applicable): _____

Witness: _____

Date: _____