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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: ☐ John L'Ecuyer, MD ☐ Judy K. Martin, MD
☐ Richard Brewington, MD ☐ Rachel James, APRN

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: ____________