# Release of Information Form for Consults in Wellness, PLLC
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# Phone 910-208-0258, Fax 910-338-0328

**I prefer to receive records by:** □ MAIL □ I WILL PICK UP □ FAX (Faxes only allowed if < 15 pgs and transmitting directly to another medical office)

**Check one:** I will □ supply 16 GB USB Flash Drive □ pay $10 for office supplied Flash Drive*
**COST:** Beginning October 2016, the cost of processing records is $20. A check can be mailed or invoice sent to your email. □ I am mailing a check □ I will drop off payment □ Invoice me at the email below
**Processing address:** PO BOX 1654, Wrightsville Beach, NC 28480. You may mail check attached to this form made to "Paths in Wellness"

## Authorization to Use/Release/Disclose Medical Information

Patient Name (please print) _____
Date of Birth_____/_____/_____ Social Security Number _____
Street Address_____**Email** _____
City_____ State_____Zip_____
Home Phone_____ WorkPhone_____ Ext._____

**Persons/Organiz. Receiving Info; [If records are for personal use - WRITE "SELF" on Name Line]**
Name _____
Physician/Provider Name (if applicable) : _____
Address _____
PHONE#_____ FAX #_____

**I, _____, I hereby authorize the following information be released:**
_____Copies of all Medical Records _____Progress Notes _____History & Physical
_____ Pathology Reports _____Radiology Reports _____Laboratory Reports
_____Other (please specify)_____

**For the following dates:** _____/_____/_____ to _____/_____/_____
OR the following years _____ OR all records

**_____I do _____I do NOT authorize release of information related to AIDS/ HIV, Communicable disease, Psych assessments, and alcohol and/or drug abuse.**

**Purpose or use of disclosure:**
_____Transferring to another physician (please give reason) _____
_____Patient's Request _____Moving
_____Other (please specify) _____

**I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations.**

_____ _____
**Signature of Patient or Guardian** **Date**