Wilmington Internal Medicine, P.A.

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Authorization for Release of Medical Records

Patient Name:____________________________________

Date of Birth:____________________________________

Social Security number:___________________________

Reason for Release:_____________________________

I authorize the following information to be released:

____ Entire Medical Records

____ Medical Records for the date(s) of service: From:_________ To:_________

____ONLY the following specific information:

____

I understand that my records may include information relating to AIDS or HIV, psychiatric and psychological care, alcohol/drug abuse and this information may be released._________(Initial here)

I understand that any disclosure of information carries with the potential for disclosure and that information may not be protected by federal confidentiality rules. ___________(Initial here)

I understand that this authorization will expire 1 year after signed unless otherwise noted.________(Initial here)

I understand that I may revoke this authorization at any time.___________(Initial here)

Patient Signature:____

Printed Name:________________________________ Date:___________________________________

Witness:____

Name of Physician(s) and or Facility (ies) records are to be requested from OR forwarded to:
(PLEASE CIRCLE ONE)

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