WELLSPRING
FAMILY PRACTICE

Medical Record Release

I hereby authorize:

Name of disclosing party

Address

City | State | Zip

To disclose to:

Name of recipient

Address

City | State | Zip

RECORDS AND INFORMATION FOR THE PAST TWO (2) YEARS PERTAINING TO:

Patient name (list other names used) | SSN | Date of Birth

Address | Phone number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

- ☐ Medical information _____ (initials)
- ☐ Psychiatric information — Signature | Date
- ☐ Drug/Alcohol Information — Signature | Date
- ☐ Results of HIV Test — Signature | Date
- ☐ Genetic Records — Signature | Date
- ☐ Other Health Information _____ (initials and specify below)
- ☐ Specify the records to be disclosed: _____

This authorization ☐ **does** / ☐ **does not** discontinue my care through WellSpring.

The recipient may use the health information authorized on this form for the following purposes:

_____

Signature | Date | If signed by other than patient, indicate relationship

(A copy of this authorization is as valid as the original. Patient has a right of receive a copy of this authorization.)

A part of allcare Medical Group

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