MEDICAL RECORDS RELEASE

Patient ________________________________ DOB________________ AKA _________________________

I HEREBY AUTHORIZE THE RELEASE OR REVIEW OF THE FOLLOWING INFORMATION FROM AND TO THE PARTIES NAMED HERE:

From:		To:	
	WellTrac Facility of Physicians		______________________ Name
	1855 N. McCarran Blvd. Address		______________________ Office Name
	Sparks, NV 89431 City, State, Zip Code		______________________ Telephone Number
	775-360-2811 Telephone Number		______________________ Fax Number

What date of service do you want released? _______________________

Information to be released: (Patient must initial each item to be released)

__ Discharge Summary   __ History and Physical   __ Laboratory Tests   __ X-ray and EKG

__ Consultation Notes   __ Other – Please be Specific: ____

Reason for release of records: ____

Expiration Date: This authorization is good for 90 days from the date signed unless revoked by me in writing and submitted to the privacy officer at WellTrac. I understand that if the person(s) and or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and my health information could be redisclosed without my authorization. I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization.

I understand that I have a right to receive a free copy of this authorization. Copy requested and received:

__ NO __ YES   INITIAL:_________

I release the person/agency, disclosing this information from any liability arising from the release of information to the person/agency designated above.

NOTICE - RELEASE OF ALCOHOL & DRUG ABUSE RECORDS: The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the disclosure of or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

____   ____________________

Signature of Patient   Date

____   ____________________

Signature of Witness   Date