

Authorization to Release Protected Medical Information

Patient's Last Name:	First:	Date of Birth:	
Street Address:		Home Phone:	
City:	State:	Zip Code:	Cell Phone:

I hereby give Full Circle Neuropsychiatric Wellness Center authorization to (specify):

- Release Information to *: Obtain information from:

Company/Provider/Person Name:	
Address:	
Phone:	Fax:

Covering the period(s) of treatment from _____ to _____ / All

Information Requested:

For the purposes of:

- | | |
|---|---|
| <input type="checkbox"/> Records – Date(s) specified above | <input type="checkbox"/> Coordination of care with another provider |
| <input type="checkbox"/> Lab Work – Date(s) specified above | <input type="checkbox"/> Moving/Transferring Care |
| <input type="checkbox"/> Records DO NOT need to be sent | <input type="checkbox"/> Insurance/Disability/Legal |
| <input type="checkbox"/> Other (specify) _____. | |

I understand that I must allow a TWO WEEK processing period. *Also, I understand that there will be a fee associated when requesting medical records. The fee (s) associated with this request will be the sole financial responsibility of the patient and/or their authorized representative. There is a reasonable fee consisting of \$0.50 per page for the first 50 pages, \$0.25 for each additional page, a flat fee of \$10.00, plus any postage costs if you request that the copies be mailed. This fee is due in advance of the medical records being released.

I understand that this authorization will expire in **ONE YEAR** unless otherwise indicated here:

- Until records are obtained 6 months Never Other: _____ . I understand I may revoke or edit this authorization at any time by providing written notification to Colleen A. Blanchfield, M.D.; however this will not affect actions taken prior to the receipt of my alteration. In the case of a minor, this authorization will expire once the patient turns 18 years of age.

Printed name of Patient or Authorized Representative

*If you are not the Patient, indicate relationship to Patient: Parent or Legal Guardian Power of Attorney

Signature of Patient or Authorized Representative

Date