Medical Records Release Form

By signing this form, I authorize Get Well, LLC to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:____ Date:_________________________________

The Information you may release subject to this signed release form is as follows:

□ Complete Records □ History & Physical □ Progress Notes

□ Lab Reports □ Radiology Reports □ Treatment Record

□ Operative Reports □ Medication Record □ Other , please specify ____________

____

***Release my protected health information to the following (circle one)**
Physician/ person/ facility/ entity and/ or those directly associated in my medical care.

Name:____

Address:____

City:____________________________ State:______ Zip Code:_________

The purpose/reason for this release of information is as follows:____

Witness:____

_________________________________ Patient Name

_______________________________________ Signature of Patient or Personal Representative

_________________________________ Printed Name of Personal Representative

_______________________________________ Description of Personal Representative's Authority

________________________ Patient Date of Birth

*****No charge for records sent to doctors until January 31st.**

*****70¢ per page for records sent to other entities or released to patients OR**

***** $15.00 a CD for complete records**