Michael F. Cantwell MD, MPH
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Medical Records Release Form

Patient Name: _____ Date of Birth: _____

I hereby authorize the office of Dr. Cantwell to obtain (get) and disclose (give) the following information from health records.

Do you want us to:

- ☐ Obtain Medical Records Due date if applicable_____
- ☐ Disclose Medical Records Due date if applicable_____

(Please allow 2wk turnaround)

Obtain/disclose Information to/from:

- ☐ NAME/ OFFICE:_____
- ☐ PHONE: _____
- ☐ FAX:_____
- ☐ EMAIL:_____

What can/do you want discussed during the consultation?

- ☐ All Medical Records
- ☐ All Medical & Mental Health Records
- ☐ Covering the Dates: _____ to _____
- ☐ Other: _____

_____

_____

In addition to the records above would you like us to discuss information relating to (check if applicable):

- ☐ Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Human Immunodeficiency Syndrome (HIV)
- ☐ Behavioral health service/psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

When disclosing records a fee of $20.00 must be paid for less than 30 pages and $40.00 for any records over 30 pages. Only testing ordered by Dr. Cantwell will be released.

I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, life event or condition:

- ☐ Date: _____
- ☐ Life event:_____
- ☐ Condition:_____

Dr. Cantwell and his employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein signed:

Patient/or Legal Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____

Signature of Witness: _____ Date: _____