WFMA
Waynesboro Family Medical Associates, LLP

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, (Date of Birth) _____Phone #_____

authorize (Provider who is releasing information) _____

To release to (Specify Name/Organization/Contact Information)_____

_____ any information that may be requested regarding my physical or mental condition and treatment rendered to me during the period of _____to _____ for **the purpose of:**

_____Transfer care to a new physician _____Insurance request _____Legal request _____Other

_____

Authorization to Release to Above my pertinent or otherwise specified Protected Healthcare Information that _____**does** include _____**does not** include Mental Health, Psychiatric and Psychotherapy Records, Drug and/or alcohol related therapy or HIV/STD testing results.

Re-disclosure: I understand that following HIPPA guidelines my healthcare information may be subject to re-disclosure either for continuity of care or by my authorization to a 3rd party requestor.
Expiration/Revocation: I understand that unless otherwise specified, this authorization to release will be in effect for 1 year from the date below unless I revoke in writing to the Medical Records Department.

_____ _____ _____
Patient Guardian if applicable Date

_____ _____
Witness Date

There will be a charge for copying/mailing records to another provider/insurance company or legal purpose except specific exempt circumstances

Sent by:_____ Date Sent: _____ Sent by: Hospital Courier_____ U.S. Mail_____ Patient Pick Up_____
Other _____Information Sent: _____