WICKFORD FAMILY MEDICINE LLC

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____
(First Name) (Middle) (Last Name)

Street Address:

_____

Town: _____ **Zipcode** _____

Date of Birth:_____
Month Day Year

WICKFORD FAMILY MEDICINE is authorized to **furnish /receive** (circle one):

Medical Practice Name: _____

I AUTHORIZE RELEASE OF MEDICAL RECORDS:

❑ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information related to the history, diagnosis, treatment in connection with any condition. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of psychiatric illness, substance abuse or sexual issues.

Please supply: 1) Problem List 2) Medication List 4) Consults 3) Recent Labs and Imaging 4) Vaccinations 5) Hospital Summaries Please send the latest visit. PLEASE DO NOT send every patient visit. Thank you.

❑ I GIVE PERMISSION TO RELEASE ONLY RECORDS described below:

_____

I release Wickford Family Medicine LLC., and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Wickford Family Medicine LLC.

_____
Patient Signature (Parent or Guardian, if minor) Date

320 PHILLIPS STREET SUITE 204
NORTH KINGSTOWN, RHODE ISLAND 02852
PHONE: 401-294-9949 • FAX: 888- 621-0422