Incoming Medical Records Release: Authorization for Release of Medical Records.
Please fax records to: Wellness Boutique LLC
Tel 843-639-6012 Fax 877-767-2691

Name _____ **Date of Birth** _____

SS# _____ **Phone** _____

Request to Copy/lnspect: I authorize the use/disclosure of health information about me as described below. The following organization is authorized to make the disclosure: Get records from:

_____

Telephone: _____ Fax: _____

Dates of service: _____
OR: or within one year prior to the last dates of service if the date last seen was earlier. Complete Medical Record, History and Physical, Labs, Office notes, Radiology imaging results, Operative reports, Discharge summaries, Prenatal records, Immunization records, Medications list, Consultation reports, & Other (please list):

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—I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and/or treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by state and/or federal law. Further, I understand that your facility may receive compensation for copying medical records in accordance with law.
TO: This information may be disclosed to and used by the following individuals or organization — please give to:
Please circle one: —Further Medical Care —Insurance Eligibility/Benefits —Inspection/Copying of my records — Legal Investigation or Action —Personal —Changing Physicians —Other (please specify):
—I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information complied in anticipation of use for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvement Amendments of 1988, and certain other records.
—I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for. benefits. I may inspect or copy any information used or disclosed.
—I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.
—I understand that I may revoke this authorization at any time, however I must do so in writing. This revocation will not apply to information which has already been released and that this authorization will expire in 90 days.

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Signature of patient Date

If this is signed by another person, please state your name, relationship and given authority to do so. Patient is a Minor Incompetent Deceased Disabled Legal authority Custodial parent Executor of estate of deceased Legal guardian Power of attorney for health care Authorized legal representative

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Signature of witness Date