# Medical Records Release

I, the patient, hereby authorize the use or disclosure of my health information from the sending health practitioner as described below to the requesting practitioner. I understand that information used or disclosed pursuant to this authorization may be disclosed

by the recipient and may no longer be protected by federal or state law. This medical information may be used by the person I authorize to receive this information for

medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that my treatment, payment, enrollment or eligibility for benefits will not be

conditioned on whether I sign this authorization.

Patient Information

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sending Health Practitioner

Willow Women’s Health – Abigail Butler, CNM, BC-WHNP

367 US-1, South Building, Suite 1

Falmouth, Maine, 04105

Phone: 207-781-0011

Fax: 207-781-0012

I authorize Willow Women’s Health - Abigail Butler CNM, BC-WHNP to release and/or disclose the medical information as indicated below to the healthcare provider, entity, or person indicated below.

DURATION: This authorization shall become effective immediately and shall remain in effect until [ ], or for 1 year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

PURPOSE (Please check one):

* Continuation of care
* Transfer of care
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of my complete health record with the exception of the following information (please initial any areas you do not want included in your record):

• \_\_\_\_\_ Mental health records

• \_\_\_\_\_ Communicable diseases (including HIV and AIDS)

• \_\_\_\_\_ Alcohol/drug abuse treatment

• \_\_\_\_\_ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial which type of information is to be released and/or disclosed.

• \_\_\_\_\_ General medical information from \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_ (dates)

• \_\_\_\_\_ Laboratory tests (serum, urine) from \_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_

• \_\_\_\_\_ Information regarding specific diagnosis or treatment from \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_.

• \_\_\_\_\_ Other (nutrition, dental)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting Practitioner Information:

Health Practitioner Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient & Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPAA PRIVACY ACT

CONFIDENTIAL / HIPAA-Approved Form