BEYOND WELLNESS

Medical Records Release

DATE: _____

PATIENT'S NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

INFORMATION OR RECORDS TO BE RELEASED:

_____

_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED:

FROM: _____ TO: _____

_____ _____

_____ _____

_____ _____

I AUTHORIZE BEYOND WELLNESS TO RELEASE/RECEIVE THE CONFIDENTIAL HEALTHCARE RECORDS OF THE ABOVE LISTED PATIENT. I UNDERSTAND THAT I MAY RESTRICT THE DISCLOSURE AT ANY TIME. IT IS UNDERSTOOD THAT THESE RECORDS CAN INCLUDE ANY AND/OR ALL RECORDS RELATING TO MEDICAL AND/OR MENTAL HEALTH CONDITIONS, DRUG/ALCOHOL DIAGNOSIS AND TREATMENT, HIV RELATED TREATMENT AND DIAGNOSIS. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY MY PROVIDER IN THE TREATMENT OF MY MEDICAL CONDITION.

I UNDERSTAND THAT I WILL BE RESPONSIBLE TO PAY BEYOND WELLNESS $.50/PAGE UP TO 50 PAGES AND $.25/PAGE THEREAFTER, TO PHOTOCOPY AND RELEASE MY MEDICAL RECORDS.

PARTY AUTHORIZED TO RELEASE RECORDS _____

DATE _____ WITNESS _____

THIS RELEASE EXPIRES ONE YEAR FROM DATE OF SIGNATURE. THIS INFORMATION WILL NOT BE RELEASED WITHOUT THE APPROPRIATE SIGNATURE. PARTIES RECEIVING RECORDS RELATED TO THIS CONSENT MAY NOT REDISCLOSE WITHOUT A SEPARATE WRITTEN CONSENT EXCEPT FROM A PROVIDER WHERE PERMITTED BY LAW.

Updated 5/2024