AUTHORIZATION FOR RELEASE
AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **SEND** medical information **TO:**

Clinic/Physician: _____

Specialty: _____

Address: _____

City: State: Zip: _____

Phone: _____

Fax: _____

Please **REQUEST** medical information **FROM:**

Dr. John Wills M.D.
5425 W. Spring Creek Pkwy, #210
972-608-3333 phone
972-473-7333 fax
www.drmedwedeff.com

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse.

Release and/or disclose records and information regarding:

_____ _____/_____/_____ _____
Name of patient Date of Birth Phone Number

_____ _____ _____ _____
Address City State Zip Code

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for ninety days from the date of signature if no date entered.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

___Entire medical records __ Progress Note ___Radiology ___Medication History
___History and Physical __ Chart Summary ___Pathology ___Immunization History
___Physician Consultation __ Labs Results ___Physician Report

If Other (please specify) _____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only: ___Physician or Health Care Facility ___Legal ___Personal
Other (please specify) _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____
Signature of patient or legal representative Date Relationship to patient