Chart # _____

WilmingtonEye

## Authorization for Disclosure of Health Information

1. **Patient's Name** _____

   **Date of Birth** _____

   **Telephone** _____

   **Address** _____

2. **I am requesting that my records be sent FROM:** _____
   (Dr./Medical Facility)

   **Phone:** _____ **Fax:** _____

3. **Please send records TO:** _____
   (Dr./Medical Facility/Self)

   **Phone:** _____ **Fax:** _____

4. **Reason for request (optional):** _____

5. **Covering the period of healthcare from** _____ **to** _____

6. **I understand this could include information about AIDS, HIV, behavioral or psychiatric care, alcohol or drug abuse.**

7. **I understand that this authorization may be revoked in writing at any time.**

8. **The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.**

9. **Please allow several business days for processing.**

**Please provide records:**

**Electronically** **Paper**

Signed: _____
(patient) (date)

_____
or (legal representative) (relationship to patient) (date)

_____
(signature of witness) (date)

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