35998 Zion Church Rd. - Frankford, DE 19945 - 302-278-0093 (phone) - 302-278-0096 (fax)

Authorization to Receive Medical Records/ Information

I authorize the release of my medical records by the organization of physician listed below:

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ Fax #: _____

Reason for Records Release: _____

These records are to be sent to Wellness by the Sea at the address listed above. (In Logo)

Patient's Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

SSN: _____ Phone #: _____

The type and amount of information to be disclosed is initialed as follows: (specify dates where appropriate)

Entire Medical Record _____ Substance & Drug Abuse _____

Recent 3 years of Records _____ HIV/AIDS _____

Psychological/ Psychiatric _____

Other: _____

*I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specific by this authorization or to my insurance company. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure of information and the information may not be protected by federal confidentiality rules.

Signature: _____ Date: _____

Signature: _____ Date: _____

Parent/ Guardian/ Representative Relation to Patient