Authorization to Release Confidential Medical Records

I, _____ authorize the following:

FROM:

Name of Doctor's Office: _____
Name of Physicians: _____
Street Address: _____
CIty, State, Zip :_____
Phone: _____ Fax: _____

TO:

WeCare Medical Associates

611 Emancipation Hwy Ste 101 Fredericksburg, VA 22401
www.wecarema.com www.facebook.com/wecaremallc
Phone: 540-656-2950 Fax: 540-656-2957

Patient Name: _____
Date of Birth: _____

Information to be Release (Check all that apply):
____ Summary ____ Med List ____ Last 2 Office Visits
____ Last Set of Labs (CBC, CMP, TSH, Vitamin D, ETC)
____ Specialist Consult _____ Radiology

Comments:_____

_____

_____

*VA law allows for copy charges of the following $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche. I hereby authorize, allow , and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release WeCare Medical Associates to form, and release and covenant not to sue WeCare Medical Associates for any claim that I have or may have in the future for release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may request to inspect or copy information at any time Except where actions have already been taken on the basis of the release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event, or condition described as.

Patient Signature/Responsible Party: _____ Date:_____
Witness Signature: _____ Date:_____