INTERNAL MEDICINE & PEDIATRICS WELLNESS CENTER
6038 W. Nordling Loop • Crystal River, FL 34429
PH: (352) 563-5070 FAX: (352) 759-4322
WWW.DRWELLNESSCENTER.COM

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:____ **Date of Birth:** ______________

Previous Name:____Social Security #:________________

I request and

to release healthcare information of the patient named above to:

Carlene Wilson MD • 6038 W. Nordling Loop • Crystal River, Fl 34429

This request and authorization applies to: ____

Healthcare information relating to the following treatment, condition, or dates:______________________

____

All healthcare information from the last 3 years____

Other: ____

All healthcare information ____

____

☐ Yes ☐ No ________________ I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

☐ Yes ☐ No _______ I understand that I have the right to receive a copy of this authorization as well as refuse to sign this authorization and that, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization

Patient Signature:____Date Signed: _______________

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED