

Internal Medicine & Pediatrics Wellness Center  
6038 W Nordling Loop  
Crystal River Fl 34429

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: Carlene Wilson MD

Address: 6038 W Nordling Loop

City: Crystal River State: Fl Zip Code: 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