Your Wellness Sources
6305 Ivy Lane, Suite 101
Greenbelt, Maryland, 20770
Phone: 301-235-0060
Fax: 240-757-0434

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

SECTION 1

NAME:_____ _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH:____-_____-_____ ss#_____-_____-_____ PRIMARY PHONE# _____
MO DAY YR

ADDRESS:_____ CITY: _____ STATE:____ ZIP:_____

SECTION 2

I hereby Authorize:
PROVIDER'S NAME/HEALTH CARE INSTITUTION:_____

ADDRESS: _____

PHONE:_____FAX:_____

to RELEASE my Protected Health Information (Medical Records), as indicated in section 3,
TO: YOUR WELLNESS SOURCES
6305 IVY LANE, SUITE 101
GREENBELT, MARYLAND 20770
FAX: 240-757-0434

SECTION 3

MEDICAL INFORMATION	**DATES**
☐ History and physical exam	_____
☐ Lab reports ……	_____
☐ Progress notes ……	_____
☐ X-ray, MRI, CT, US reports	_____
☐Mammogram, DEXA ……	_____
☐ Other ……	_____

I specifically authorize the release of information relating to:
☐ Substance abuse (including alcohol/drug abuse)
☐ Mental health (excluding psychotherapy notes)
☐ HIV related information (including AIDS related testing)

X _____ _____
SIGNATURE OF AUTHORIZED PERSON **DATE**

SECTION 4

1. I understand that this authorization will expire 365 days from the date I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by The Wellness Source, LLC (DBA, "Your Wellness Sources) for the purpose of: _____.
a. My health care and payment for my health care will not be affected if I do not sign this form.
b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
5. I understand that in compliance with Maryland statute, I will pay a fee per MPCP/PMG's Access of Health Information Fee Schedule (available upon request) for copying and inspection of records.

SECTION 5

X_____ _____
AUTHORIZED SIGNATURE **DATE**

☐ Self ☐ Durable Power of Attorney* ☐ Parent ☐ Health Care Agent*
☐ Legal Guardian ☐ Other_____

A COPY OF THE LEGAL DOCUMENTATION VERIFYING AUTHORIZATION MUST BE ATTACHED.

AUTHORIZED SIGNATURE VERIFIED BY:_____
YWS STAFF INITIALS