Tel: 302-401-0606 **Fax: 214-433-6327** **www.bwmedmd.com**
info@bwmedmd.com

Release of Medical Information

Permission to get records

I, ____________________________,with a date of birth,____________, give my permission for
(patient name) (patient's DOB)

______________________________to give my medical records to BWMedMD
(doctor's or hospital name who has records)

Permission to get sensitive information

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:
____________ my mental health,
____________transmittable disease I may have like HIV/AIDS,
____________genetic records, and/or
____________drug and alcohol records.

I understand that:

- **I do not have to give my permission to share these records.**
- **If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.**
- **This form is good for 5 years from the date I sign it.**

Consent for release of medical records for ______________________________________
(patient name)

Date: ________________________________

Requesting records from:

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info@bwmedmd.com

Name of Practice:________________________________

Name of Physician:________________________________

Fax number:____________________________________

Address:_______________________________________

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor visit notes
☐ Emergency Room notes
☐ Urgent care notes
☐ History and physical
☐ Hospital Progress Notes
☐ Operation or procedure notes
☐ Clinic notes
☐ Pathology reports
☐ Doctors orders
☐ Nurses notes
☐ Discharge Summary
☐ Lab reports
☐ Radiology Reports
☐ Consultations
☐ Other ______________________________

Records within the following dates:

☐ **All records for this patient**

☐ **Records dated between ____________________and _____________________**

Patient's Signature____ Date _____________

Authorized Representative's Signature________________________ Date_____________

Relationship of Authorized Representative_______________________________________