Debra S. Shapiro, MD
Lisa B. Golding, MD
A. Margaret Sandin, MD

RESERVOIR MEDICAL ASSOCIATES

David M. Shein, MD
Ricardo L. Wellisch, MD
Sarah Saalfield, APRN

MEDICAL RECORD RELEASE

Information on office releasing records:

Name/Facility: _____

Complete Address: _____

Patient Information (please print)

Patient's Name_____ Date of Birth «DOB» _____

Complete Address: _____

Contact Telephone _____ SSN _____

Release Information to Reservoir Medical PCP:

☐ A. Margaret Sandin M.D.
☐ Debra Shapiro, M.D.
☐ Lisa Golding, M.D.
☐ David Shein, M.D.
☐ Ricardo Wellisch, M.D.
.

Information to be Released (check all that apply)

☐ Complete Chart
☐ Discharge Summary
☐ Laboratory Tests
☐ Operative Report
☐ Office Visit Notes
☐ Pathology Reports
☐ Imaging Reports
☐ Other (please specify) _____

Authorization (authorization remains valid for 90 days from date of signature)

Patient Signature: _____ Date: _____

Parent/Guardian _____ Date _____

Authorization for Release of Sensitive Information

This medical record may contain certain sensitive or statutorily protected information. Please indicate the information you would like released. A separate signature is required.

☐ Mental Health Information
☐ Social Service Information
☐ Domestic Violence Information
☐ Sexual Assault Information
☐ Alcohol/Drug Abuse Information
☐ Sexually Transmitted Diseases

Patient Signature: _____ Date: _____

Parent/Guardian _____ Date _____

HIV Testing and AIDS Treatment

This medical record may contain HIV testing and AIDS treatment information. I authorize the release of this information to the person/facility named in this form, for a ***single release*** only.

Patient Signature: _____ Date: _____

Parent/Guardian _____ Date _____

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