RESERVOIR MEDICAL ASSOCIATES

Debra S. Shapiro, M.D. A. Margaret Sandin, M.D. Mary Katz, N.P.
Lydia Barlow, M.D. Karen E. Victor, M.D.
Lisa B. Golding, M.D. Ricardo L. Wellisch, M.D.

MEDICAL RECORDS REQUEST RELEASE FORM

Patient Information (please print)

Patient Name: _____ **Patient DOB:** _____

Patient Address: _____

Patient Telephone: _____ **Patient SSN:** _____

Facility Releasing Record Information

Name of Facility or Physician: _____

Address: _____

Telephone: _____ **Fax:** _____

Information to be Released to Reservoir Medical PCP:

- ☐ Debra Shapiro, M.D.
- ☐ Lisa B. Golding, M.D.
- ☐ Lydia Barlow, M.D.
- ☐ A. Margaret Sandin, M.D.
- ☐ Karen E. Victor, M.D.
- ☐ Ricardo L. Wellisch, M.D.
- ☐ Mary Katz, N.P.

Information to be Released:

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

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 indicated the information you would like release. A separate signature is required.

- ☐ Mental Health Information
- ☐ Domestic Violence Information
- ☐ Alcohol/Drug Abuse Information
- ☐ Social Service Information
- ☐ Sexual Assault 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:** _____