Michael J. West, M.D., Ph.D.

Board Certified in Endocrinology, Diabetes and Metabolism

DonnaWestervelt, MS, CRNP, CDE

Diabetologist

Tammy Peng, RD, LD

Registered Dietitian

**Medical records release form**

This form is to be used to obtain a FULL copy of your entire chart for yourself or to have medical records transferred or sent to another physician.

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

Patient's address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Requesting records and relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I authorize you to release confidential health information about

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient), including a full copy of the patient's medical records, or a full summary/narrative of the patient's protected health information, to the person(s) or entity listed below.

**Limitations on the information you may release subjected to this release are as follows:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release protected health information to the following person(s)/entity:**

(If you are the patient and are releasing these records to yourself only, then please write your name and address below.)

You’re Name or your new doctor's name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor's office name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2440 M Street, NW ▪ Suite 417 ▪ Washington, D.C. 20037

Phone 202-570-5151 ▪ Fax 202-446-2946

**HIV/AIDS:** I **DO** **DO NOT** consent to the release of any positive or negative test result for AIDS or

HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my

Medical records.

**Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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The reasons or purposes for this release of information are as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgment**

**(Please check each box and sign below. This form will not be processed if all boxes are not checked.)**

My signature below and my check-marks in the boxes gives permission for theWashington Endocrine Clinic to

Fax these records to the above entity.

I understand that the Clinic can only transfer records related to the care provided by physicians at the Washington Endocrine Clinic. My check-mark and signature below indicates that I understand the Clinic does not have the right to release other records from other physicians, including those that I had

Originally had sent to the Washington Endocrine Clinic from other doctors' offices, will be included.

I understand that a $25 administration fee will be charged to my credit card for preparing and faxing this information. (The Clinic only accepts cash or credit card payments.) My check-mark and signature below indicates that I understand this and that there is no exceptions to this fee.

I understand that the Clinic has up to 3 working days to complete this request.

I understand that these records will only be sent via a fax # only. My check-mark and signature below indicates that I understand there is no exceptions to this requirement.

Patient Signature [or parent, guardian or legal representative]

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are paying by Credit Card you must provide the following for this form to be processed:**

Credit Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp date \_\_\_\_\_\_\_\_\_\_\_\_\_ Security code \_\_\_\_\_\_\_\_

Street number or house number of where the Credit Card billing statement is sent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For example, if you live at 9925 Main St, Anywhere USA 12345 then you write in the space above “9925”

Zip code of where the Credit Card billing statement is sent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For example, if you live at 9925 Main St, Anywhere, USA 12345 then you write in the space above “12345”

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