GW ID: ____________

# RELEASE OF LABORATORY RECORDS

Patient's Name: ____________________________________ Date of Birth: _____________

I hereby authorize White-Wilson Medical Center, P.A. to disclose the following Protected Health Information pertaining to the above referenced patient to:

Name of Person or Entity: ____________________________________________________________

Address: ____________________________________________________________________________

City, State, Zip Code: ______________________________________________________________

Telephone Number: _________________________ Fax Number: _________________________

Please release the following results for:

________ Lab Reports Date(s) of Service: ____________________

________ Pathology Reports Date(s) of Service: ____________________

________ Other (Please Specify): ______________________________________

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the information.

______________________________________ ________________________________
Signature Date

______________________________________ ________________________________
Print Name Relationship (if not patient)

______________________________________
Released by/Date