Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: _____ DOB: ____/____/_____
Records being requested from:
Dr. _____ Phone Number: _____ Fax Number: _____

HIV/AIDS: I consent to the release of any positive or negative test results 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: ____/____/_____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Record
- ☐ Progress Notes
- ☐ H&P
- ☐ Other (please specify below)
- ☐ Lab Reports
- ☐ Radiology Report
- ☐ Rx Records
- ☐ Pathology Reports
- ☐ Immunization Records
- ☐ Hospital Reports

_____

_____

_____

Release my protected health information to the following physician/facility:

Dr. Mary Bell Vaughn
Vineville Internal Medicine
3448Vineville Avenue
Macon, GA 31204

The purpose/reason for this release of information is as follows:

_____

Signature:

_____ Patient Name

_____ Signature of Patient or Personal Representative

_____ Patient DOB or Social Security Number

_____ Printed Name of Patient or Personal Representative

____/____/_____ Date

_____ Description of Personal Representative's Authority