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: _____
Dr. _____ Phone Number: _____ Fax Number: _____

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

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

_____
_____

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. If this applies, please initial and date this form. Initial:_____ Date:__/__/___

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

Dr. Mary Bell Vaughn
Vineville Internal Medicine
3448 Vineville Ave
Macon, Ga 31204

Phone: 478-405-0045
Fax: 478-405-0054

Patient Name (Please Print) _____ DOB: ___/___/_____

Signature: _____ Date: ___/___/_____