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# Medical Records Release from Hartwell Family Practice, P.C.

Patient's name Social Security Date of Birth

To whom do you wish Hartwell Family Practice, P.C. to release your records to?
Name of person/Facility, Address, Phone or fax number as applicable

I hereby authorize Hartwell Family Practice, P.C. to release my
( ) complete medical record
( ) partial record
( ) specific date _____

Including information in reference to: (check all that apply)
( ) drugs and/or alcohol abuse
( ) Psychiatric
( ) venereal disease
( ) Social services
( ) Hepatitis B testing/treatment
( ) HIV testing/treatment
( ) Other _____

This authorization is valid for 90 days and may be revoked in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release Hartwell Family Practice, P.C. from any liability or legal responsibility in connection with the release of the above information. I do not give permission for any other use or re-disclosure of this information.
**I also accept the risk and consequence of faxing medical records.**

| Patient Signature | Guardian Signature (if under 18) | Witness | Date |
|---|---|---|---|

**Below is for HFP Use Only**
Date Received: _____ Date Sent:_____ Initial:____ Mailed:_____ Fax: _____ Pick up:_____