THE WASHINGTON ENDOCRINE CLINIC PLLC

Michael J. West, M.D., Ph.D.
Board Certified in Endocrinology, Diabetes and Metabolism

Donna Westervelt, 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.

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: _____**

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.)

Your 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
www.washingtonendocrineclinic.com ▪ washingtonendocrineclinic@gmail.com

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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 the Washington 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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