NEWCare
New England Wound & Ostomy Care

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

We can honor your request only if this form is filled out completely.

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize New England Wound Care, LLC to ☐ release medical records to: ☐ receive medical records from:

Individual/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release is authorized for the following specific purpose(s) or activities:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other_____

The information to be disclosed should include:

☐ Entire Medical Record ☐ Visit Notes ☐ History & Physical ☐ Lab Reports ☐ Radiology Reports
☐ MRI & CT Scans ☐ Specialist Reports ☐ Mental Health Notes

This authorization covers a 180 day period from the date on this document unless otherwise specified: _____.

I understand that information used or disclosed as a result of this authorization may not be further used or disclosed without my express written permission. I acknowledge that I have signed this authorization voluntarily. I also understand that I may revoke this authorization at any time in writing except to the extent that action has been taken in reliance on it.

Printed Name: _____
(Patient or Legally Authorized Representative)

Relationship to Patient: _____

Signature: _____ Date: _____