

Windsor Rx
 7100 Commerce Way, Suite 285
 Brentwood, TN 37027



1-800-316-2273
 www.windsorhealthplan.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to **Windsor Health Plan, Inc. or to any of their employees** upon request in person, by mail, or facsimile.

Provider: <i>(name and address)</i>	Patient: SS#: DOB:
RECORDS AUTHORIZED TO BE RELEASED:	
<input type="checkbox"/> Admission history and physical <input type="checkbox"/> Discharge summary <input type="checkbox"/> Complete hospital chart <input type="checkbox"/> Office notes <input type="checkbox"/> Outpatient records	<input type="checkbox"/> Lab reports <input type="checkbox"/> Radiological images <input type="checkbox"/> Consultation notes or reports <input type="checkbox"/> Complaints or grievances filed, with responses or dispositions <input type="checkbox"/> Psychiatric and other mental health records
<input type="checkbox"/> Medication administration logs, dietary logs, contact or service logs, and other records that may not be part of my individual medical record, but which contains information relating to me. <i>(These records should be redacted to protect information pertaining to other patients.)</i>	<input type="checkbox"/> Records relating to drug/alcohol abuse <i>(must specify extent or nature of records to be released)</i> staff <input type="checkbox"/> Other <i>(specify):</i>
Extent or nature of records to be released (example, specific hospitalization or visit):	
I understand that my medical record may include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or acquired immune deficiency syndrome (AIDS) and/or HIV status.	
This information will be used for the purpose of :	
<input type="checkbox"/> Other activities at the request of the individual <input type="checkbox"/> Medical Care <input type="checkbox"/> Other, please explain:	<input type="checkbox"/> Determination of Insurance Coverage/ Reimbursement

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to **Windsor Health Plan, Inc.** but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that: <ul style="list-style-type: none"> I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal. Federal privacy regulations will no longer apply to the information disclosed, and that Windsor Health Plan, Inc. may re-disclose the information. I am entitled to receive a copy of this authorization. A copy of this authorization may be utilized with the same effectiveness as an original. 	<div style="border-bottom: 1px solid black; margin-bottom: 10px;">Patient or Representative Date</div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;">Name of Representative (print)</div> <div style="border-bottom: 1px solid black;">Relationship to Patient</div>
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