

WindsorSterling
 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:
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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"/> 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"/> 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"/> 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>
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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"/> Determination of Insurance Coverage/ Reimbursement
<input type="checkbox"/> Medical Care	
<input type="checkbox"/> Other, please explain:	

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. 	<hr/> Patient or Representative Date <hr/> Name of Representative (print) <hr/> Relationship to Patient
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