



# Ginter Wellness Primary Care Medical Records Release

Elisa Ginter DO & Carrie Jo Prather DO, Board Certified in Primary Care

## REQUESTING PHYSICIAN

Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

## CUSTODIAN OF RECORDS

Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF THE FOLLOWING PERSONAL HEALTH INFORMATION TO/FROM THE PARTIES LISTED ABOVE: (CIRCLE ALL THAT APPLY)

THE ENTIRE MEDICAL RECORD; LAST LAB/PATHOLOGY RESULTS; LAST CONSULT NOTE;  
HOSPITAL RECORDS, HEART RELATED STUDIES (EKG, ECHOCARDIOGRAM, STRESS TEST);  
RADIOLOGY REPORTS (MRI, CT, US, X-RAY of the \_\_\_\_\_; MRI, CT, US, X-RAY of the \_\_\_\_\_)  
OTHER: \_\_\_\_\_

FROM THE PERIOD OF \_\_\_\_\_ THROUGH \_\_\_\_\_.

THIS TRANSFER OF RECORDS SHOULD INCLUDE THE FOLLOWING CONFIDENTIAL RECORDS (Check):

- HIV/AIDS TESTING, CARE OR TREATMENT
- DRUG OR ALCOHOL ABUSE TREATMENT
- MENTAL HEALTH TREATMENT

\_\_\_\_\_  
**PATIENT NAME**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE OF BIRTH**

\_\_\_\_\_  
**TODAY'S DATE**

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