DR. PATTY POWERS MD

WHOLE HEALTH CATALYSTS, P.C.

Authorization to Request Medical Records from Another Doctor or Practice

Patient Name: _____

Date of Birth: _____

I authorize Whole Health Catalysts, PC to **request** a copy, summary, or narrative of my medical records **as indicated by the checkmark (s) below**, or otherwise release confidential information to Whole Health Catalysts, PC.

□ Complete records
□ Records of care from the following dates:_____
□ Records concerning the following conditions:_____
□ Other, please specify:_____

HIV/AIDS (If Applicable) **I 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: _____

Request records from the following Physician (s) or other entity:

Name: _____

Street: _____

City: _____State:_____Zip:_____

Phone: _____ Fax: _____

Send to:

Name: Dr. PATRICIA POWERS, MD WHOLE HEALTH CATALYSTS, P.C.
Address: 20304 TIMBERLAKE RD
City: LYNCHBURG State: VIRGINIA Zip: 24502
Phone: 434-382-1825 Fax: 434-208-2682

Expiration Date: _____ or Expiration Event as detailed below:

- I understand that I may revoke this authorization in writing. Revoking this authorization will not affect uses or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosures by the recipient and no longer protected by Federal or State Law.

Patient Signature: _____ Date: _____

Authorized Representative: _____Relationship to Patient: _____

Revised Feb 13, 2023