



# It Is Well Healthcare

Amanda D. Boone, APRN  
33 Gooden Ave  
Dover, DE 19904  
(P) 302-678-9355 (F) 302-678-9310

I authorize the below-named health care provider to release the information or records specified upon request in person or by mail to the address specified at the time of the request.

Previous Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please release the information to: <b>It Is Well Healthcare</b> <b>33 Gooden Ave Dover, DE 19904</b> <b>(P) 302-678-9355 (F) 302-678-9310</b>	<b>Patient Name:</b>  <b>DOB:</b>
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Specific Information Authorized to be released:

<p>Medical Record from (insert date) ___/___/___ to ___/___/___</p> <p>Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers.</p> <p>Other: _____</p>
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This information will be used for the purpose of the following as needed:

Investigating an allegation of abuse Other activities at the request of the individual Verifying my eligibility for services offered by	Legal Representation Providing advocacy services
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- \* I understand that 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 It Is Well Healthcare may redisclose the information.
- \* I am entitled to received a copy of this authorization
- \* A copy of the authorization may be utilized with the same effectiveness as an original

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date