WH0458HIM
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Previous Edition Is Obsolete

Authorization for Use and/or Disclosure of Protected Health Information

Wayne HealthCare 835 Sweitzer Street • Greenville, Ohio 45331

Medical Record# ____________________

This form authorizes Wayne HealthCare to use and/or disclose protected health information in the manner described below and is voluntary. Wayne HealthCare will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations.

STOP Please note that each section of this form must be completed in its entirety. Failure to specify (including dates) will delay the processing of your request.

PATIENT INFORMATION

Patient Name: ____
Last First Middle Maiden (if applicable)

Date of Birth: ____________________ Phone: ____________________ Gender: ☐ Male ☐ Female

Parent/Guardian/Requestor Completing Form: ____

Requestor Email Address (optional): ____

Note: Email addresses will be utilized strictly to facilitate the processing of your request. No protected health information will be conveyed in this manner.

RELEASE TO

Name: ______________________________ Organization (if applicable): ______________________________

Street Address: ____

City/State: ______________________________ Zip Code: ____________________

Telephone: ______________________________ Fax: ______________________________

Information May Be: ☐ Mailed ☐ Reviewed Only ☐ Discussed via Telephone ☐ In Person Meeting ☐ Picked Up By: ____________

PURPOSE

Records are to be released for the following purpose(s): (Select all that apply)

☐ Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Other: ____________________

☐ At the request of the individual

INFORMATION TO RELEASE

Dates of Treatment/Particular Illness/Admission Requested: ____

☐ Patient/Physician Abstract- pertinent information generally used for continued care/personal use. ☐ All records

(See the reverse of this form for information regarding what is included in a Patient/Physician Abstract)

☐ Discharge Summary ☐ Emergency Department Record ☐ X-Ray Reports, Labs or Other Tests

☐ History & Physical ☐ Immunizations ☐Consultation Reports, Specify MD: ____________

☐ Operative Reports ☐ Registration Sheets ☐ Outpatient Clinic Notes, Specify Clinic(s): ____________

☐ Other: ______________________________

Note: Psychotherapy notes must be requested through a separate authorization.

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION

Unless otherwise revoked, this Authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired): ____________________. This Authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the Authorization, the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department at the address below. Please refer to Wayne HealthCare's Notice of Privacy Practices. If Wayne HealthCare requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form, if requested.

I, the undersigned, hereby authorize Wayne HealthCare to use and/or disclose information from my (or give relationship) medical as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

X Signature: ____ Date: ____________________

If person other than patient signing, identify relationship to patient (check one): ☐ Parent ☐ Legal Guardian ☐ Durable POA for Healthcare

Note: If Legal Guardian or POA box is checked, documentation establishing relationship must be provided or on record in order to comply with the above request.

SUBMIT

Please verify that all sections are completed in full.
Upon completion, please send the form to:

Wayne HealthCare
Health Information Management
835 Sweitzer Street
Greenville, Ohio 45331

OR

Fax the form to: (937) 547-5738

Request has been fulfilled: ☐ Yes, Initials: ____________ Date: ____________