WH0458HIM
Issued 1/13, revised 8/17
Previous Edition Is Obsolete

Authorization for Use and/or Disclosure of Protected Health Information

Wayne HealthCare • 835 Sweitzer Street • Greenville, Ohio 45331 • Main: (937) 547-5732 • HIM Fax: (937) 547-5738

IMPORTANT – PLEASE READ:
Charges for this request may apply (ORC 3701.741). Allow up to 30 days for processing. Medical Record #_____

I hereby grant permission for release or review of the following information relating to my care from and to the parties named here:

From: _____ To: _____

_____ _____

_____ _____

PURPOSE

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

☐ Continuity of Care/Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance Claim ☐ Disability/SSI

☐ At the request of the individual ☐ Other: _____

PATIENT INFORMATION

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

Date of Birth: _____ Phone: _____

Parent/Guardian/Requestor Completing Form: _____

Requestor Email Address (optional): _____

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

INFORMATION TO RELEASE

Dates of Treatment/Particular Illness/Admission Requested: _____

☐ All records (legal/attorney – Certified)

☐ Facesheet	☐ Physician Orders	☐ Pathology Report
☐ Discharge Summary	☐ Emergency Department Record	☐ X-Ray Reports, Labs, Cardiopulmonary Results
☐ History & Physical	☐ Immunizations	☐ Consultation Reports
☐ Operative Reports	☐ Registration Sheets	☐ Outpatient Clinic Notes, Specify Clinic(s):
☐ Photos / Images	☐ Psychotherapy	

☐ Other(s): _____

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

Patient Initial for Psychotherapy notes:_____ Date:_____

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION

I understand that the information I authorized a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. **I understand that this authorization is voluntary and I may refuse to sign this authorization**. My refusal to sign will not affect my ability to obtain treatment and Wayne HealthCare cannot refuse to treat me due to my failure to sign this document. I understand that this authorization may be withdrawn at any time in writing (See Privacy Notice). This authorization will be in effect for **sixty (60) days** after sign and date form below unless I specify an earlier expiration date in this space:_____

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). I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse patient records (42 CFR Part 2), and this notice accompanies disclosure of such information.

X Signature: _____ Date: _____

If person other than patient signing, identify relationship to patient (check one): ☐ Parent ☐ Legal Guardian ☐ HCPOA
Note: If Legal Guardian or HCPOA box is checked, documentation establishing relationship must be provided or on record in order to comply with the above request.

Information May Be: ☐ Mailed ☐ Reviewed Only ☐ Discussed via Telephone ☐ In Person Meeting
☐ Picked Up By: _____
Request has been fulfilled: ☐ Yes, Initials: _____ Date: _____