PLASTIC SURGERY
Wright State Physicians

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Authorization to Release Medical Information

To: _____ From: _____

_____ _____

_____ _____

Patient Name /Date of Birth (DOB): _____ / _____

I. Description of information to be used or disclosed that identifies the information in a specific and meaning fashion. (Complete this section.)

Specific information to be disclosed:

- ☐ Face Sheet
- ☐ History & Physical
- ☐ Physician Progress Notes
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ All medical record information
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

II. The purpose of the authorized use or disclosure of the information described above is as follows: (Complete this section.)

- ☐ Patient request
- ☐ Patient representative ☐ spouse ☐ child ☐ Power of Attorney (POA)

III. The effective term of the authorization. (Complete this section.)

- ☐ This authorization will expire on ____/____/____ (date)
- ☐ None
- ☐ End of research study ____/____/____ (date if known)

IV. Identify person(s) to whom Wright State Physicians may disclose or receive the Protected Health Information. (Complete this section.) Send medical information to:

_____

_____

_____

_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered under federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of Wright State Physicians, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Wright State Physicians in reliance on this authorization, by sending a written revocation to Wright State Physicians practice location where I see my provider. I hereby authorize use or disclose of protected health information about me as described above. Wright State Physicians may not condition treatment, payment, enrollment or eligibility for benefits on whether release of information is authorized.

_____	_____	_____
Signature of Patient/Client OR, If Applicable	Date of Signature	Date of Birth or Last 4 digits of Social Security Number
_____	_____	_____
Signature of Guardian Personal Representative Power of Attorney (POA)	Date of Guardian's Personal Representative(s) Signature	Description of Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the individual or other Signator.