



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 meaningful fashion. **(Complete this section.)**

Specific information to be disclosed:

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> All medical record information
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultation Reports	
<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> 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 with 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 deccribed 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 disclosure 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

Date of Signature

Date of Birth or Last 4 digits of
Social Security Number

OR, If Applicable

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.