



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Phone:** _____ **Date of Birth** ___/___/___
Address: _____ **City** _____ **State** ___ **Zip** _____

1. Specific information to be disclosed (check below):

- Encounter & Procedures Clinical Documents Vaccination List
 Imaging Results Laboratory Results Medication List

Dates of Service—REQUIRED: _____

2. The purpose of the authorized use or disclosure of the information described above is as follows:

- Patient request Patient representative Spouse Child Power of Attorney (POA)

3. Effective term of authorization:

- No expiration Authorization expires on: ___/___/___ Research study ends on: ___/___/___

4. Identify to whom Wright State Physicians may:

- Receive from: _____
 Disclose to: _____

Send the above referenced protected health 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 by 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 the 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 a release of information is authorized.
- I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Signature of Patient/Client	Date of Signature	Date of Birth (or last 4 digits of Social Security Number)
OR, if applicable:		
Signature of Guardian or Personal Representative of Patient's Estate	Date of Guardian's or Personal Representative's Signature	Description of Authority to Act for the Individual

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.