Wright State Physicians

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.