WILSON HEALTH

RELEASE OF INFORMATION

915 West Michigan Street
Sidney, Ohio 45365

Phone: 937-498-5310
Fax: 937-498-5516
Email: medrec@wilsonhealth.org

Wilson Health and Wilson Health Medical Group each recognizes and supports each patient's right of access under The Health Insurance Portability and Accountability Act (HIPAA). Records are available electronically and in real time through the MyChart patient portal. For requests submitted to the Medical Records Department, please allow up to 30 days for chart completion and processing. Charges may apply to these Medical Records requests.

By signing the release form below, I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal Privacy Regulations. I understand this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain medical treatment.

Patient Name: _____ **Patient Date of Birth:** _____

Requestor: (check one)

☐ Self (Patient) ☐ Patient Representative, Name _____

If Patient Representative, check one below AND validate parent or HPOA documents.

☐ Parent/Guardian ☐ HPOA ☐ Executor of Estate ☐ Other: _____

Purpose of Request:

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

☐ Transfer of care;

To/From: _____

Address: _____

Phone/Fax: _____

Email: _____

☐ Other: _____

Information to be accessed or Released (Only check boxes that apply)

☐ All Wilson Health Hospital and Wilson Health Medical Group Records

☐ Wilson Health Medical Group Records (select below):

☐ Wilson Health Hospital Records Only (select below):

☐ Face Sheet	☐ Laboratory Report	☐ Therapy Reports
☐ History & Physical	☐ Operative Report	☐ Emergency Treatment
☐ Discharge Summary	☐ Pathology Report	☐ Consultation Report
☐ Physician Progress Notes	☐ Radiology Reports	☐ Physician Orders

☐ Other: _____

Date(s) of Service to Release: _____

For internal use only: Last updated 4/2026

Patient MRN #:	Patient Acct #:	Patient CSN #:
Date Requested:	Date Completed:	Completed By:

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Protected Records:
The information in your health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.

State and Federal Law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	Yes ☐	No ☐	Dates: _____	Initial _____
HIV Testing and Results	Yes ☐	No ☐	Dates: _____	Initial _____
Mental Health Records	Yes ☐	No ☐	Dates: _____	Initial _____
Psychotherapy Records	Yes ☐	No ☐	Dates: _____	Initial _____

How would you like record copies delivered?

☐ Paper Copy ☐ Electronic Copy via USB/Flash Drive ☐ Email Copy

☐ Self/In-Person Pickup

☐ Authorized Representative Pick Up, Name: _____

☐ Mail Delivery, Street Address: _____

City/State/Zip: _____

If you selected email, please provide Email Address: _____

Please Note: Once records leave Wilson Health—whether by paper, email, flash drive, or any other approved method—Wilson Health is not responsible for the protection or security of those records outside our secure environment. Any email delivery of records will be done via encrypted communication.

_____ _____

Signature of Patient or Patient Representative **Date**

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Patient MRN #:	Patient Acct #:	Patient CSN #:
Date Requested:	Date Completed:	Completed By: