WILSON HEALTH

Medical Records Department
915 W. Michigan Street
Sidney, Ohio 45365

IMPORTANT MESSAGE – PLEASE READ: Charges may apply to this request. Outpatient Test Results and Emergency Department Reports are available 24 hours after the records are processed. All other records are available upon chart completion, which may require 14 days.

Updated 07/2/2015

MR# _____
ACCT# _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person do hereby authorize the release of my medical information, as indicated herein, between the following parties:

From: Wilson Health
Medical Records Dept.
Phone: 937-498-5310
Fax: 937-498-5516

To: _____
_____
_____
_____

I authorize this release of information to either ☐ verify services rendered to process a claim for benefits, ☐ to provide continuity to my medical care, ☐ at the request of the individual, ☐ other_____.

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 that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space_____. I understand, also, that except to the extent that has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved. (see Notice of Privacy Practices).

It is my desire that only the information in my ☐ inpatient record, ☐ clinic record, ☐ emergency record, ☐ ambulatory testing (please check the appropriate boxes) indicated below is to be released as a result of this authorization:

☐ Face Sheet	☐ Laboratory Reports	☐ Therapy Reports
☐ History & Physical	☐ Operative Reports	☐ Emergency Treatment
☐ Discharge Summary	☐ Pathology Reports	☐ Other specified here:
☐ Consultation Reports	☐ Physician Progress Notes	_____
☐ Radiology Reports	☐ Physician Orders	_____

I am also making the following additional qualification: IF the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I am including this type of information to be released in association with this authorization.

_____ _____ _____
(Date) (Patient or Guardian Signature) (Witness)

☐ HCPOA ☐ Executor ☐ Guardianship forms received

Patient Name:_____ Birthdate:_____
Address:_____
Telephone Number:_____

Request received by:_____ Request submitted by_____ ID verified by:_____