Western Wayne Physicians

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MEDICAL INFORMATION RELEASE AUTHORIZATION

Instructions
Fill in the appropriate information in each applicable section. Sign and date the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Maiden Name: _____
Last First Initial

Date of Birth: _____ Last 4 Digits of SS# _____ Sex M/F Telephone: ( )_____

Address: Street: _____

City:_____ State: _____ Zip: _____

I, _____ herby authorize _____ to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. However, such notes may contain information on general medical care; alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or hepatitis; demographic information; and treatment received at other health care providers.

1. Name and title of person or organization and address to whom information is to be:

☐ Disclosed to: _____ ☐ Requested From:_____

_____ _____

_____ _____

_____ _____
Address Address

2. The purpose or need for such disclosure:
____At the request of the patient ____Personal Use ____Continuation of Care ____Attorney
____Workman's Compensation ____Insurance ____Disability ____Other:_____

3. Specific information to be disclosed/obtained as related to #2.
_____ Office Visits _____ Radiology _____ Entire Record
_____ Labs _____ Immunizations _____ Psychotherapy Notes
_____Operative Reports _____Other (specify)_____

4. This authorization is valid only if received by Western Wayne Physicians within 90 days of the date signed.

5. Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ (date cannot exceed one year from the date of signature below).

6. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.

7. My care or treatment will not be conditioned on signing this authorization.

8. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

9. Western Wayne Physicians and/or its copying services reserve the right to charge for processing and copying information.

Signature: _____ Relationship (if other than patient):_____
Patient, Parent of Minor, Legal Guardian, Date:_____
Personal Representative, Heir at Law, Person under POA*

Witness: _____

*If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release.