Wildwood

Authorization to Release Health Care Information

Patient Name: _____ DOB: _____ Phone: _____

I understand that health care information is confidential and will not be released without my authorization unless permitted by law. I understand that I have the legal right to refuse authorization to disclose all or some health care information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

I hereby grant permission to the authorized employees or agents of (**released from**):

Dr/Practice Name: _____ Phone: _____

Providers are required by law to release the minimum amount of information necessary to carry out the purpose of a release. Check mark and then use the line beside each document type below to indicate the date or range of dates for written information to be disclosed under this authorization, as appropriate.

RELEASE the following information:

___ ***Entire medical record***___ Cardiology reports: _____
___ Progress notes: _____ Consults: _____
___ Lab results: _____ Ongoing verbal communication
___ Radiology reports: _____ Other (specify):_____

Information may be RELEASED TO (**receiver**):

Company:

Address:

Phone: **Fax:**

The information and material above may only be used for the following purpose(s):

___ Transfer of care___ WC Claim ___ Insurance application___ Legal matter(s)___ Disability/FMLA
___ Other _____

I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

Check the following specific authorization:

AIDS/HIV: ___ I DO authorize ___ I DO NOT authorize
Alcohol and/or drug abuse treatment: ___ I DO authorize ___ I DO NOT authorize
Mental health service: ___ I DO authorize ___ I DO NOT authorize

This authorization expires (12) twelve months from the date hereof. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date, but will prevent further release of information. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

My signature below indicates that I have read this release form and have had all of my questions answered, if any.

I understand the following:

- What this form authorizes and consent to the release of information as recorded on this form.
- I authorize the party(ies) listed in section 1 of this form to make subsequent disclosures to the same recipient pursuant to this authorization.
- That information released might be further released by the receiving party, and that if this occurs, Wildwood Medicine cannot guarantee the protection of this information once disclosed.
- That I have a right to request a copy of this authorization.

Patient or Representative Signature **Date**

___ Parent___ Legal guardian___ Other legally authorized representative (specify) _____