

WYOMING COUNTY COMMUNITY HEALTH SYSTEM

400 North Main Street Warsaw, New York 14569
Phone: (585) 786 - 8940 ext. 4429 FAX: (585) 786 - 1248

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ FORMER/MAIDEN NAME: _____

CURRENT ADDRESS: _____

BIRTHDATE: ___/___/___ TELEPHONE: (HOME) _____ (WORK) _____

I AUTHORIZE INFORMATION RELEASED FROM:

PLEASE RELEASE MY RECORDS TO:

Name of Facility

Name of Requestor

Address

Address

City, State, Zip

City, State, Zip

PURPOSE OF RELEASE: (Please check box)

- Medical Insurance Legal Comp At the request of the patient

NOTE: INFORMATION RELEASED IS LIMITED TO THE MINIMUM NECESSARY FOR THE STATED PURPOSE

*** This consent covers treatment period from _____ to _____.

TYPE OF INFORMATION TO BE RELEASED

SPECIFIC INFORMATION ONLY:

- HISTORY AND PHYSICAL X-RAY, EKG
DISCHARGE SUMMARY EMERGENCY ROOM REPORT
LAB, PATHOLOGY TETANUS

OTHER:

PERMISSION TO FAX INFORMATION: YES NO

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot always be guaranteed.

Protected or Sensitive Information: I understand that certain information cannot be released without specific authorization as required by State/Federal Law.

BY INITIALING: I authorized the release of the following protected or sensitive information:

MENTAL HEALTH RECORDS AIDS/HIV INFORMATION (State law requires separate consent - attached)

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event or condition, THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE OF SIGNING.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and no longer protected by Federal privacy regulations.

** I understand that I need not sign this form in order to ensure healthcare treatment, payment, enrollment in my health plans, or eligibility for benefits.

Signature of patient/legal representative Relationship to patient

Witness: Date: ID verified (if applicable)