WYOMING COUNTY COMMUNITY HEALTH SYSTEM
400 North Main Street Warsaw, New York 14569
Phone: (585) 786 – 8940 ext. 4482 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:

_____
Name of Facility

_____
Address

_____
City, State, Zip

PLEASE RELEASE MY RECORDS TO:

_____
Name of Requestor

_____
Address

_____
City, State, Zip

PURPOSE OF RELEASE: (Please check box)

☐ Medical ☐ Insurance ☐ Legal ☐ Comp ☐ At the request of the patient

NOTE: INFORMATION RELEASE 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

☐ DISCHARGE SUMMARY

☐ LAB, PATHOLOGY

☐ OTHER:

☐ X-RAY, EKG

☐ EMERGENCY ROOM REPORT

☐ TETANUS

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 authorize 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)