WYANDOT MEMORIAL HOSPITAL

885 North Sandusky Avenue
Upper Sandusky, Ohio 43351
Phone 419.294.4991 - Fax 419.294.4750

AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES

(other than substance abuse use disorder provider programs)

Fields marked with an asterisk(*) are required to be completed. Failure to provide additional identifying information may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524.

Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.

Section I

FIRST NAME *	M.I.	LAST NAME *	DATE OF BIRTH *	SOCIAL SECURITY # (last 4) XXX – XX –

ADDRESS	CITY	STATE	ZIP CODE

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

DISCLOSING ENTITY * *(covered entity such as a health plan/insurer or provider)*

ADDRESS		PHONE NUMBER
CITY	**STATE**	**ZIP CODE**

RECIPIENT (Person or Entity) *

CONTACT INFORMATION *(e.g. phone number, email address, fax number, street address, etc.)*

Section III

REASON FOR DISCLOSURE *

HEALTH INFORMATION TO BE DISCLOSED *

SPECIFY TIME PERIOD, if desired:
Release only information from the period _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

EXPIRATION DATE OR EVENT

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rules [45 CFR Part 164].

SIGNATURE OF INDIVIDUAL *	Date * *(mm/dd/yyyy)*
SIGNATURE OF PERSONAL REPRESENTATIVE (if applicable) * *(identify relationship to individual below)*	**Date *** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual * *(personal representative shall submit proof of authority to the disclosing agent)*

☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administrator ☐ Other ☐ N/A

For administrative use only:

Method of Delivery (e.g. paper, fax, electronic, etc)	Date Released