Authorization for Release of Medical Information

Patient's Name | Date of Birth | Date of Request

Patient's Street Address | City | State & Zip Code | Phone Number

For the Patient: I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that I may revoke this authorization at any time by notifying WellMed in writing. However, the revocation will not have an effect on any actions WellMed took before receiving the revocation.

I authorize WellMed to receive from or disclose my protected health information to the following person or organization:

Name of Person/Group **Requesting** Information | Name of Group **Sending** Information

Mailing Address & City | Mailing Address & City

State & Zip Code | Fax number | State & Zip Code

Description of individually identifiable health information to be received or disclosed (Check all that apply):

❑ Treatment Plan(s) ❑ Progress Reports ❑ Other (describe): _____

❑ All pertinent information WellMed deems appropriate for the purpose checked below.

The purpose of this authorization (Check all that apply):

❑ Transfer of Records to New Provider ❑ To allow the appropriate management of treatment or services

❑ Subpoena or other legal process ❑ Other (describe): _____

The dates of records to be disclosed (MM/DD/YYYY): From: _____ To: _____

The patient or patient's legally appointed representative must complete the rest of the form.

I understand that this authorization will expire:

❑ _____ (MM/DD/YYYY) ❑ One year from the date of the signature below

❑ Once the following event occurs: _____

Signature of Patient or Patient's Legal Representative | Print Name & Relationship to Patient | Date