WILSON MEMORIAL HOSPITAL
WILSON CARE, LLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I Hereby Authorize: **To Release To:**

_______________________________ ____
Name of Physician's Office Name of Physician/Health Care Facility/Agency/Other

__________________________________ __________________________________
Street Address Street Address

__________________________________ __________________________________
City, State & Zip Code City, State & Zip Code

____
Telephone Number

Information to be released:

☐ All clinical Records ☐ Progress Notes ☐ Lab Reports ☐ Immunization Records ☐ Other: ________________

Purpose of Need for Disclosure: (Please check appropriate categories)

☐ Change of Physician ☐ Application for Insurance ☐ Continuity of Care ☐ HIV ☐ Personal

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal privacy regulations. I understand that this authorization is subject to revocation by me (us) at any time except to the extent that action has been taken in reliance thereof. If I choose to revoke this authorization, I understand I must do so in writing, and send to: Wilson Care, LLC, 915 W. Michigan St., Sidney, OH 45365. I also understand that this authorization will expire within sixty (60) days from the date of my signature unless otherwise specified.
If I decide not to sign this form, it will not affect my current or future healthcare at Wilson Care, LLC, current or future payments to Wilson Care, LLC, ability to enroll in any health plans, or eligibility for benefits. The under signed releases Wilson Care, LLC from all legal liability that may arise from the release of information requested.
PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality may be protected by Federal and State law. Federal regulation 42 CFR Part 2 prohibits you (the recipient) from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations and state law. A general authorization for the release of medical or other information in NOT sufficient for this purpose.

Records Requested on: ____
Patient Name (please print)

____
Date of Birth

AUTHORIZATION:

____ ______________________
Signature of Patient Date

____ ______________________
Signature of Other Authorized Person Relationship to Patient

____ ID Checked: ☐ Yes ☐ No
Signature of Witness

________________________________ _________________________ ____________________________
Released by Date Department