Van Wert Health

1250 South Washington Street
Van Wert, Ohio 45891
(419) 238-2390

Medical Records Phone: (419) 238-8684
Medical Records Fax: (419) 238-4668
Requesting Floor:___________________
Phone #:_____________ Fax #:__________
Verified Identification: Y / N How:____________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

- ______________________________, ______________________, ___________________
  (Patient's Full Legal Name) (Previous Name) (Date of Birth)

  ____ ______________________
  (Address) (Phone #)

- From: ___________________ To: __________________________
  (Agency) ___________________ (Agency) ______________________
  ___________________ ______________________

- Specific information to be released:
  ____
  ____

- I hereby release the above information for the purpose of _____________________________

- I understand that treatment, payment, enrollment, or eligibility is not conditioned by my signing this authorization.
- Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules.
- This information may be mailed, picked up or transmitted via facsimile. Allow 7 to 10 working days after completion of the Medical Record. I hereby authorize the review and/or release of information, including, if applicable, specific laboratory tests of HIV infection or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions. If the above information includes alcohol and/or drug abuse, psychological or mental health or developmental disabilities, I hereby authorize this inclusion of information.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THE INFORMATION THAT MAY BE REVIEWED AND/OR RELEASED BY IT: ☐ **Yes** ☐ **No**

- I understand that I may withdraw this authorization at any time but must do so in writing. This authorization shall remain in effect for sixty (60) days unless withdrawn in writing. The above information will not be given, sold, transferred or in any way relayed to any person not specificed in this authorization without first obtaining my additional written consent. I further agree that the Hospital or its agents may charge me or any designated recipient the cost incurred in preparing the copy of the requested medical records. A copy of this authorization shall be as valid as the original.

____________________________	____________________________________
(Signature of Patient)	(Signature of Parent, Guardian, Power of Attorney)
____________________________	____________________________________
(Date)	(Relationship)
____________________________	____________________________________
(Witness)	(Date)