Van Wert Health

Authorization For Release of Medical Records

Medical Records | 419-238-8684 (Phone) | 419-238-4668 (Fax)
Requesting Floor_____ Phone_____ Fax_____
Verified Identification ☐ Yes ☐ No How_____

Patient's Last Name First MI	Previous Name	Date of Birth
Present Address - Number and Street City	State Zip	Phone

From (Provider) _____

To (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

READ CAREFULLY BEFORE SIGNING

I understand that I may withdraw this authorization at any time but must do so in writing. Thisauthorization shall remain in effect for sixty (60) days unless withdrawn in writing. The aboveinformation will not be given, sold, transferred or in any way relayed to any person not specificed in thisauthorization without first obtaining my additional written consent. I further agree that the Hospital orits 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.

_____ Applicant's Signature

_____ Signature of Parent, Guardian, Power of Attorney

_____ Date

_____ Relationship

_____ Witness

_____ Date

Form revised March 2022