ORTHOPAEDIC SURGERY
SPORTS MEDICINE & REHABILITATION
Wright State Physicians

Miami Valley Hospital
30 E. Apple Street, Suite 2200
Dayton, OH 45409-2939
Tel 937.208.2091
Fax 937.208.6141

Atrium Medical Center
200 Medical Drive, Suite 375
Franklin, OH 45005
Tel 513.705.4201
Fax 513.705.4223

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:_____

Phone: _____Date of Birth (DOB): _____

Address: _____

City: _____ State:_____Zip: _____

COMPLETED SECTIONS 1 - 4

1. *Description of information to be used or disclosed that identifies the information in a specific and meaningful fashion.*
   Specific information to be disclosed:
   □ Face Sheet □ Discharge Summary □ History & Physical
   □ Physician Progress Notes □ Radiology Reports □ Laboratory Reports □ Consultation Reports
   □ Other _____
   [ ] All medical record information

2. *The purpose of the authorized use or disclosure of the information described above is as follows*:

   □ Patient request □ Patient representative □ spouse □ child □ Power of Attorney (POA)

3. *The effective term of the authorization.* □ None
   □ This authorization will expire on ___/___/___ □ End of research study ___/___/___
   (date) (date if known)

4. Identify *person(s) to whom Wright State Physicians may disclose or receive the Protected Health Information (PHI*).
   Send Medical Information to:

_____

_____

_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of Wright State Physicians, I understand that I may revoke this authorization in writing at any time, except, to the extent that action has been taken by Wright State Physicians in reliance on this authorization, by sending a written revocation to Wright State Physicians practice location where I see my provider. I hereby authorize use or disclosure of protected health information about me as described above. Wright State Physicians may not condition treatment, payment, enrollment or eligibility for benefits on whether a release of information is authorized.

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____	_____	_____
Signature of Patient/Client	Date of Signature	Date of Birth or Last 4 number of Social Security Number
_____	_____	_____
Signature of Guardian	Date of Guardian's/Personal	Description of Authority to Act

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.