

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

Records from: _____

Send to: **WESTERN MEDICINE, INC.**
Circle one:
Dean Groth Becker, NP Kuhn,PA-C
P. O. Box 339
Enon , Ohio 45323
Phone: (937) 864-7363
Fax Number : (937) 864-5895

***** **SEND ONLY REQUESTED RECORDS** *****

- | | | |
|--|--|--|
| <input type="checkbox"/> Consult Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other: (Specify) |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Emergency /Hospital | |

I understand that information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol / drug (substance) abuse or any such related information.

Description of the purpose of the use and/or disclosure: (check one)

- | | | |
|---|---|--|
| <input type="checkbox"/> Transfer of Care/Selecting new Physician | <input type="checkbox"/> Relocating out of town | <input type="checkbox"/> Specialist Care |
| <input type="checkbox"/> Consult / Second Opinion | <input type="checkbox"/> Attorney / Court Case | <input type="checkbox"/> Insurance Carrier Request |
| <input type="checkbox"/> Other: (Specify) _____ | | <input type="checkbox"/> Continuity of Care |

I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy regulations. I understand Western Medicine, Inc. may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event)

I further understand that I may revoke this authorization at any time by notifying the parties involved. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient Representative _____
Date

If signed by a representative, state relationship to Patient : _____

LEGAL AUTHORITY : _____
[attach supporting documentation]

To assist you with this request, I am providing you with the following identifying information:

_____ Print Name	_____ Street Address
_____ Date of Birth	_____ City
_____ Phone #	_____ State
	_____ Zip Code