WESTERN MEDICINE, INC.
Authorization for Transfer/Release of Health Information

I, _____ **_____**
Print Patient Name **Date of Birth**

Authorize:

WESTERN MEDICINE. INC.
P.O. Box 339
Enon, Ohio 45323
(937) 864-7363 and Fax: 864-5895

To Disclose To:

Aaron T. Groth, M.D.
Northside Family Practice
280 Red Coach Drive
Springfield, Ohio 45503

_____ I hereby authorize the release of information for the above patient's health care records.

This disclosure is being made for the following purpose(s):

___ Continuing care
___ Attorney/court case
___ Worker's compensation
___ Other
_X_ Transfer of care
___ Insurance carrier requests
___ Personal reasons

This authorization for disclosure of information is effective for one year from the date signed. This informed consent is subject to revocation at any time by written notification only.

X_____ _____
Patient Signature (or Parent or Legal Guardian) Date

This medical record may contain information about drug and alcohol abuse, alcoholism, venereal diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

___ I Do consent to have this information released
___ I Do Not consent to have this information released
____ Not Applicable

_____ _____
Patient Signature (or Parent or Legal Guardian) Date

This medical record may contain information containing HIV testing and/ or AIDS diagnosis treatment. Separate consent must be given before this information can be released.

___ I Do consent to have this information disclosed
___ I Do Not consent to have this information disclosed
____Not Applicable

_____ _____
Patient Signature (or Parent or Legal Guardian) Date