INSTRUCTION FOR COMPLETING THE AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Following are instructions, by section, to aid in the completion of this form:

SECTION 1 - Demographic:

Please provide the patients' information. Please complete in full.

SECTION 2 – Type of access request:

Please check one. "Copies of Record" or "Inspection of Record" - Is your request for copies or would you prefer to just review the medical record.

Treatment dates: List all the dates of treatment for which you need information.

Please check what reports you are wanting. Example: Please check "Lab" if that is the only information needed. This will help us to provide only the needed information.

SECTION 3 – Identification of Entity authorized to receive PHI:

"I hereby authorize" – Please indicate "Wesley Medical Center" unless the request is for medical records from another facility. Is so please indicate that facility or person.

On the next line, write in the name and complete mailing address of the person to whom the information is to be mailed. We must have the person's name who is to receive the information, name of the company, and complete mailing address before we can release any information.

SECTION 4 – Expiration:

Please provide an expiration date – the date you want this authorization to expire. If you want this authorization to be valid for 1 year than circle "Not to exceed 1 year".

SECTION 5 – Purpose:

Indicate why the records are needed, i.e. continued care, personal use, insurance, etc.

SECTION 6 – Statement of Understanding:

The patient or their legal representative must sign and date the authorization for it to be valid. The legal representative must indicate their relationship to the patient. If someone other than the patient (unless patient is a minor) is signing then legal documentation must be provided, i.e. a medical power of attorney, court documentation, custody papers, etc.

If you need further assistance please call Release of Information at 962-2513.