

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**  
**If mailing this request, PLEASE send a copy of your picture I.D with the authorization.**

This form must be submitted by the patient or authorized representative to request inspection and/or copies of their protected health information.

1. Patient Name: \_\_\_\_\_ Other Name(s): \_\_\_\_\_

Complete Address: \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

2. (Please check one) I wish to: \_\_\_\_\_ Inspect the record \_\_\_\_\_ Obtain copies of the record (fees apply)

3. Dates of Service: \_\_\_\_\_

4. I wish to inspect or obtain copies of the following information (check all that apply):
- |   |  |
|---|--|
| <input type="checkbox"/> Discharge Summary                                  | <input type="checkbox"/> Operative Reports             |
| <input type="checkbox"/> History & Physical                                 | <input type="checkbox"/> Consultation Reports          |
| <input type="checkbox"/> Progress Notes                                     | <input type="checkbox"/> Billing Claim Forms           |
| <input type="checkbox"/> Radiology Reports                                  | <input type="checkbox"/> Itemized Statement of Charges |
| <input type="checkbox"/> Images on CD                                       |  |
| <input type="checkbox"/> Laboratory Reports                                 |  |
| <input type="checkbox"/> Pathology Reports                                  |  |
| <input type="checkbox"/> Psychiatric or Substance Abuse Records (BEH)       |  |
| <input type="checkbox"/> All information for the specified dates of service |  |
| <input type="checkbox"/> Other; specify: _____                              |  |

5. Reason for Request: \_\_\_\_\_

6. If copies are to be picked up by someone other than the patient:  
Name: \_\_\_\_\_

7. I request Wise Health System (WHS) to provide me with access to the protected health information about myself (or patient) as described above. I understand that:
- The information released may contain information related to HIV/AIDS infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
  - WHS reserves the right to verify my identity/guardianship.
  - I have the right to revoke this authorization at any time via written revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_  
If I fail to specify a date, event or condition, this authorization will expire in 90 days.
  - If I have questions concerning disclosure of my health information, I may contact Yordanos Hagos, Privacy Officer, at 940-626-2575

Signature of Patient or Legal Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

8. Please mail copies to (address):

Name of Recipient: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mail to: Wise Health System, 609 Medical Center Dr. Decatur, Tx 76234