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):
   - ( ) Discharge Summary
   - ( ) History & Physical
   - ( ) Progress Notes
   - ( ) Radiology Reports
   - ( ) Images on CD
   - ( ) Laboratory Reports
   - ( ) Pathology Reports
   - ( ) Psychiatric or Substance Abuse Records (BEH)
   - ( ) Other; specify: _____
   - ( ) Operative Reports
   - ( ) Consultation Reports

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 Kimberly Danielson, Privacy Officer, at 940-626-2433.

Signature of Patient or Legal Authorized Representative:_____ Date: _____

Printed Name: _____ Relationship to Patient: _____

8. Please mail copies to (address)(If CD images not picked up by: _____, please mail to address below):

   Name of Recipient:_____

   Street:_____City:_____State:_____Zip:_____

   Phone: _____ Fax:_____

   Please mail to: Wise Health System-Attn: HIM Dept or Fax to 940-626-1265

   609 Medical Center Drive Decatur, TX. 76234