WMC
PHYSICIAN PRACTICES LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize WMC Physician Practices LLC to release information from the record of:

Patient Name: _____ SSN : _____ DOB: _____

Please Mail/Fax Records to:

Name of Facility/Person: _____ Phone: _____
Address: _____ Fax: _____
City, State, Zip: _____

Type of record to be released and date(s) of service (check all that apply)
_____ Inpatient / Dates: _____
_____ Outpatient / Dates: _____
_____ ED / Dates: _____

Specific information to be released (check all that apply)

_____ Consultation Reports	_____ History & Physical	_____ Physician Progress Notes
_____ Discharge Summary	_____ Laboratory Results	_____ EKG Report
_____ Operative Report	_____ Pathology Report	_____ Physician Orders
_____ ED Evaluation	_____ Radiology Report	_____ Medication Administration Record

_____ Other /Specify _____

*HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ____HIV; ____Mental Health; _____ D&A.

*I understand that this authorization is effective for a period of 90 days from the date of signature.

*I understand that I have the right to revoke this authorization at any time by sending a written request to the entity I authorize above.

*I understand that it is possible that the facility/person that receives the records may re-disclose this information, therefore (1) WMC Physician Practices and its employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule.

*WMC Physician Practices will not condition treatment, payment, enrollment or eligibility based on this authorization.

_____ _____ _____
Date Signature of Patient Signature of Parent, Legal Guardian

Released by (initials): _____
Number of pages: _____