THE WRIGHT CENTER for COMMUNITY HEALTH

Medical Release Form Instructions

To obtain a personal copy of your medical records, a records release form must be submitted to the office. The release form must be filled out **accurately** so that the request is processed in a timely manner.

1. Include your name, date of birth, address and telephone in the first field.
2. Next, please specify whether the office is releasing or obtaining the records by circling the option.
3. Include the name of the provider, person or facility (include as much as possible.)
4. Fill in the address of the provider, person or facility by including a phone and fax number.
5. Select the purpose for release. For example, if you want a personal copy you will check "At the request of the patient or the patient's legal representative for personal access of."
6. If the purpose is to send records to another facility for continuation of care the first box "continuation of medical treatment" must be checked.
7. Next, include a time period (it is necessary to have a begin and end date; if you are unsure when you began seeking care you can always use your date of birth.)
8. Select which information you would like to be released, if you would like "all records", check the "all records" box.
9. To release any psychotherapy/mental health/rehabilitation/HIV/AIDS/alcoholism/drug abuse, the designated boxes **must** be checked off. We will not release any information regarding these conditions unless specified.
10. Check either box to choose when you'd like the authorization to expire.
11. Your signature is needed on the first signature line and must be signed and dated.

To complete this form, please print and return to office directly or by mail to the following address:

The Wright Center for Community Health
Attn: Medical Records Department
5 South Washington Avenue
Jermyn, PA 18433

After the release form is submitted to the office, please allow up to 7 days to process the request. For a personal copy of your records, the records will be transferred to an encrypted disc for $10.00. A staff member will let you know when the disc is ready for pickup. You may request your records to be sent to your patient portal, free of charge.

To have your records transferred to another facility (free of charge.), a release form is also required and the same steps as above should be taken. Please allow at a minimum of 3 weeks for your records to be received from your previous provider.

If you have any questions or require assistance with the release form, please contact the Medical Record Department at 570-230-0019.

Mail to Below Address
The Wright Center for Community Health
5 South Washington Ave
Jermyn PA, 18433
Fax 570-230-0013
If faxing over 30 pages, please mail records.
Patient Authorization to Release/Obtain Protected Health Information

Patient Information:

Name DOB

Prior Name

Address

Home Telephone Cell Phone

I authorize The Wright Center to release/obtain the information described in this form to/from Name of Provider, Person or Facility:

Address of Provider, Person or Facility (Phone/Fax):

for the purpose of:
☐ Continuation of medical treatment ☐ Payment of Bill
☐ Worker's Compensation ☐ Insurance Purpose
☐ Education ☐ Legal Purposes
☐ At the request of the patient or the patient's legal representative for personal access of
☐ Other(Specify):

The information to be released/obtained covers the time period from: -

SPECIFIC INFORMATION TO RELEASE/OBTAIN:

☐ ALL RECORDS

☐ Clinic Notes (NOT psychotherapy notes)
☐ Discharge Summary
☐ Medications
☐ EEG, EKG, Stress Test
☐ Consultation Report(s)
☐ Pathology Reports
☐ Laboratory Reports
☐ Imaging Reports
☐ Immunizations
☐ ER Report
☐ Disability/FMLA Form
☐ X-Ray Films
☐ History & Physical
☐ Surgical Note
☐ Itemized Bills
☐ Endoscopy
☐ Colonoscopy
☐ Other (specified)

☐ ***Psychotherapy Notes*** (Psychotherapy Notes are recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of your medical record. Psychotherapy Notes include: medication prescription and monitoring, modalities and frequencies

of treatment furnished, and results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress and progress-to-date.) Disclaimer: The Wright Center for Community Health reserves the right to refuse to release psychotherapy notes if disclosure is deemed not to be in the best interests of the patient.
SPECIAL AUTHORIZATION: If you are authorizing The Wright Center for Community Health to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please check the boxes in front of the section which describes the type of information to be released:

☐ My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the signed authorization.

☐ My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation information may be released to the recipient noted on the signed authorization.

☐ My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/ or drug dependence. These records may also contain confidential information about communicable diseases including HIV/AIDS or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient. I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

By signing my name to this form, I understand and agree to the following:

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that if I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected pursuant to HIPAA regulations/federal law. A copy or fax of this authorization will be as valid as the original.

Cancelling This Authorization: I understand that I may change my mind and cancel this authorization at any time in writing. After the organization receives my written notice, it will cancel this release within five (5) business days. During these five days, The Wright Center for Community Health may have shared some or all of my information. Neither the organization nor any of its representatives are liable for any release of information during this time.

Right of Refusal: I have the right NOT to sign this authorization. My refusal to sign this form will not affect my/the patient's eligibility for treatment or benefits.

Revocation and Expiration: I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact The Wright Center for Community Health immediately if I wish to revoke this authorization.

Unless I revoke this authorization in writing, this authorization will expire automatically:

☐ when the records requested on this authorization have been released, or
☐ one year from the date I sign it.

The Wright Center for Community Health may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

Patient Copy: ☐ Accepted ☐ Refused

NOTE: IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

Date/Time:
Patient/Parent or Legal Guardian Signature:

If Legal Guardian or Personal Representative, proof of guardianship or Power of Attorney must be attached

Date/Time:
Witness Signature: _

Verbal Authorization: If patient is unable to sign authorization form because of emergency, physical condition or age, describe the circumstances:

Signature: Relationship:
Witness Signature: _
Date/Time:

A COPY OF THE COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT /GUARDIAN/REPRESENTATIVE

☐ As Medical Records Clerk, I have released the Minimum Necessary documentation required according to HIPAA.

Name of Staff Providing Copy to Patient/Legal guardian or Personal Representative:

Signature: Date: