Wood Health Company

Wood County Women's Care
Falcon Health Center

Patient Name: _____ Social Security Number: ____ - ____ - ____

Any Previous Names: _____ Telephone Number: _____

Birth Date: _____ (Month) _____ (Day) _____ (Year) Medical Record Number: _____

I, hereby, authorize _____ its director or agent to disclose information contained in the health (medical) record of the patient identified above. Such documentation may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC); communicable disease or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information, and treatment received at other health care providers.

1. Name or title of person or organization and address to whom information is to be made:

☐ Disclose to the following addressee	☐ Request from the following addressee
_____	_____
_____	_____
_____	_____
_____	_____

2. Purpose for Disclosure: _____
3. Information to be disclosed: _____
4. This authorization is valid for one (1) year from the date of signature and is limited to releasing only what is stated in this request.
5. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization.
6. My care or treatment will not be conditioned on signing this authorization, and I agree not hold the above designated hospital, physician, surgeon, or employee of said institution liable in acting upon this request.
7. The persons to whom the information is disclosed may possibly re-disclose the information to others without the patient's knowledge or consent and, therefore, the privacy of personal and health information may no longer be protected by law.
8. _____ and/or its copy services reserve the right to charge for processing and copying information. This fee may be waived when releasing directly to a treating physician or health care facility.

_____ _____

Signature of Patient, Parent of Minor, Legal Guardian, Personal Representative, or Power of Attorney

Relationship (if other than Patient)

Date Requested: _____ Date Received: _____

If Legal Guardian or Personal Representative or person with authority under a durable power of attorney, a copy of appropriate documentation is required for release.