Wesley
Community & Health Centers

Clinic/Appointments: 602-257-4323
FAX: 602-252-5768
Community Center: 602-233-0017
www.wesleychc.org

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ D.O.B. _____

I authorize Wesley Health Center to: □ Obtain records from □ Release information to

Facility: _____ Phone/Fax: _____

I authorize the release of the following information:

All medical records from: _____ to _____

□ Complete Record	□ Radiology Reports	□ Discharge Summary
□ Pap	□ X-Ray Records	□ Laboratory Results
□ Medication Records	□ Mammograms	□ Financial Records
□ Consults	□ Immunization Records	□ 2 most recent years
□ Progress Notes	□ Behavioral/Mental Health Records	□ STI Testing/Result

□ Other _____

For the Purpose of: _____

I authorize the provider to use or disclose information related to: (Check all that apply)

□ AIDS/HIV & or other Communicable Disease
□ Behavioral Health Care/Psychiatric Care
□ Substance or alcohol abuse treatment

I do hereby waive all provisions of law and privileges relating to the disclosure hereby authorized.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Wesley Staff Representative Signature Date

PLEASE FAX MEDICAL RECORDS TO: Wesley Health Center -Fax: 602-257-4338
NOTE: If there is a fee for the patient's medical records, please call our office prior to processing, at 602.257.4323. Thank you.