COMMUNITY HOSPITALS and WELLNESS CENTERS

Montpelier Hospital (CAH)	909 E. Snyder Ave.	Montpelier, OH 43543
Bryan Hospital	433 W. High St.	Bryan, OH 43506
Archbold Medical Center	121 Westfield Dr.	Archbold, OH 43502

7034

(patient label)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STOP *Please note that each section of this form must be completed in its entirety.*
Failure to specify (including dates) will delay the processing of your request.
Allow 2 Business Days for Processing

*Information Requested From: _____
Other Facility

Medical Record #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____
Last First Middle

Date of Birth: _____

Release To

Name/Organization: _____

Address: _____

City/State/Zip: _____ Telephone: _____ Fax: _____

Email: _____

Information May Be: ☐ Mailed ☐ Pick Up By: _____ ☐ Telephone ☐ Fax to Medical Facility ☐ CCD

Purpose

Records are to be released for the following purpose(s): *(Select all that apply)*

☐ Medical Care ☐ Attorney/Legal ☐ Personal ☐ Insurance ☐ Other: _____

Information To Release

Dates of Treatment/Particular Illness/Admission Requested: _____

☐ Entire Record ☐ Discharge Summary ☐ Emergency Department Record ☐ Radiology Reports

☐ History & Physical ☐ Registration Sheets ☐ Lab Reports ☐ Radiology Images

☐ Operative Report ☐ Other (Specify): _____

Patient/Parent/Legal Guardian Authorization

Unless otherwise revoked, the Authorization will expire 60 days from the date it is signed or, if specified, on the following date: _____. This Authorization may be revoked at any time. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Medical Records Department at the address below. Charges may apply.

I, the undersigned, hereby authorize Community Hospitals and Wellness Centers to use and/or disclose information from my medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or mental health conditions to the above mentioned entity(ies). I agree not to hold the hospital responsible for lost, stolen, or otherwise misplaced medical information that can not be reproduced.

Signature of Patient: _____ Date: _____

By signing below, I verify that I have legal right(s) to obtain the requested medical information for the patient listed above.

Signature: _____ Date: _____
Parent / Legal Guardian / Spouse / Patient Representative

Submit

Please verify that all sections are completed in full. Upon completion, please send the form to:

CHWC
c/o Medical Records Department
433 W. High Street
Bryan, OH 43506

OR

Fax the form to: 419-636-1770

For CHWC Personnel:

Request Completed By: _____ Employee #: _____ Date: _____

Witness (Telephone): _____ Employee #: _____ Date: _____

Released By: _____ Employee #: _____ Date: _____

Date/Time Released: _____