wesley Health Centers
JWCH INSTITUTE

CHECKS MUST BE PAYABLE TO:
JWCH INSTITUTE, INC.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION		
PATIENT NAME:		
DOB:	**PN#:**	
ADDRESS:		
CITY:	**STATE:**	**ZIP:**
PHONE:	**EMAIL:**	

This request and authorizes the following **Wesley Health Centers:** _____ *(Clinic Name)* To release health information of the patient named above to the requestor listed below.	I request and authorize: **Agency Name**: _____ to release healthcare information of the patient named above to the **Wesley Health Centers (requestor**) listed below.

PLEASE SPECIFY WHAT IS BEING REQUESTED

Please Check:

☐All- Complete Records ☐Medication List ☐Lab Results ☐Other: _____

Dates of Service: **FROM:**_____ **TO:** _____

REQUESTOR INFORMATION	
REQUESTOR NAME:	**Clinic (STAMP IF APPLICABLE)**
REQUESTOR ADDRESS:	
REQUESTOR PHONE:	
REQUESTOR FAX:	

PURPOSE OF DISCLOSURE

THIS DISCLOSURE WILL BE USED FOR THE FOLLOWING PURPOSE: Please Check

□ Personal Use □ Legal □ Insurance □ Medical Treatment
□ Medical Condition Verification □ Disability □ FMLA □ Other: _____

NOTE: Patient records released as part of this authorization may contain references related to mental health, addition, and HIV medical conditions.

SIGNATURES AND DATES ARE REQUIRED IF ANY OF THE FOLLOWING CATEGORIES ARE CHECKED. OTHERWISE, THIS INFORMATION WILL BE EXCLUDED.		
□ SUBSTANCE ABUSE	SIGNATURE:	**DATE:**
□ MENTAL HEALTH	SIGNATURE:	**DATE:**
□ HIV MEDICINE	SIGNATURE:	**DATE:**

SIGNATURE	
Please note: Parent or Legal Guardian must provide proof if the patient is a minor.	
PRINT NAME:	**TODAY'S DATE:**
SIGNATURE:	**EXPIRATION DATE:** ***(1 year from today's date)***
WITNESS: Staff name that reviewed document	