



Checks must be payable to:
JWCH INSTITUTE, INC.

Medical records can be requested
via our Patient Portal.
Visit wesleyhealthcenters.org to Enroll.
Please note patient Portal is for patient use only.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

<p>This request and authorizes the following</p> <p>Wesley Health Centers: _____ <i>(Clinic Name)</i></p> <p>To release health information of the patient named above to the requestor listed below.</p>	<p>I request and authorize:</p> <p>Agency Name: _____</p> <p>to release healthcare information of the patient named above to the Wesley Health Centers (requestor) listed below.</p>
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PLEASE SPECIFY WHAT IS BEING REQUESTED
<p>Please Check:</p> <p><input type="checkbox"/> All- Complete Records <input type="checkbox"/> Medication List <input type="checkbox"/> Lab Results <input type="checkbox"/> Other: _____</p>
<p>Dates of Service: FROM: _____ TO: _____</p>

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

PURPOSE OF DISCLOSURE
<p>THIS DISCLOSURE WILL BE USED FOR THE FOLLOWING PURPOSE: Please Check</p> <p><input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Medical Condition Verification <input type="checkbox"/> Disability <input type="checkbox"/> FMLA <input type="checkbox"/> Other: _____</p> <p>NOTE: Patient records released as part of this authorization may contain references related to mental health, addition, and HIV medical conditions.</p>

SIGNATURES AND DATES ARE REQUIRED IF ANY OF THE FOLLOWING CATEGORIES ARE CHECKED. OTHERWISE, THIS INFORMATION WILL BE EXCLUDED.		
<input type="checkbox"/> SUBSTANCE ABUSE	SIGNATURE:	DATE:
<input type="checkbox"/> MENTAL HEALTH	SIGNATURE:	DATE:
<input type="checkbox"/> 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	