WAYNE COUNTY
Health Department
Where Caring Meets the Community

100 S. 5th Street
Richmond, IN 47374
765-973-9245
www.co.wayne.in.us
Dan Burk, Director
Jennifer Bales, M.D., Health Officer

(Print) Patient First and Last Name _____ Social Security Number _____ Date of Birth _____

Specific Information to be Disclosed:

- ☐ Entire Record
- ☐ Immunization Record
- ☐ HIV/Hepatitis/STD Records
- ☐ Laboratory Results

Purpose for Disclosure:

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

Dates of Service:

☐ All (You are only permitted to view information dated on or prior to date of this authorization).

☐ _____(Specific Date of Service).

I hereby authorize Wayne County Health Department to obtain the above information contained in my medical record from:

Name/Address of Person/Organization

Disclose Records To:

Name	
Organization/Company	
Title	
Street Address	
City, State, Zip Code	
Telephone Number	

I authorize the release of the above information relating to my general medical treatment and/or any treatment relating to alcohol/drug abuse, mental illness, psychiatric treatment, development disabilities, HIV/AIDS, Gonorrhea, Viral Hepatitis, Syphilis, Chancroid, Chlamydial infections, or Lymphogranuloma Venereum. I further authorize the information to be faxed or electronically sent.

I understand this authorization may be revoked at any time, providing the information has not already been disclosed. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I also understand that once the above information has been disclosed per my instructions, the information may no longer be protected by the confidentiality laws. Unless otherwise specified or revoke, this authorization with expire in 60 days unless the disclosure is to myself which will automatically expire 60 days from the date of my signature on this form.

Signature acknowledges that I have read and fully understand the above statements.

Signature of Patient or Legal Guardian _____ Date _____ Driver's License/ Other ID _____ Relationship to Patient _____