



## Authorization for Release of Health Information

### Patient Information

Last Name	First Name	DOB
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Address	City	State	Zip	Phone #
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**Select one of the following:**

- I authorize WCHC to release by health information to:

ROBERT WOLF, MD	443-485-91156	443-961-9295	<a href="mailto:rwolf@wolfmedgroup.com">rwolf@wolfmedgroup.com</a>
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Name	Phone	Fax	Email
120 Ryan Drive	Rising Sun	MD	21911-1840

Address	City	State	Zip
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- I authorize WCHC to obtain my health information from:

Name	Phone	Fax	Email

Address	City	State	Zip
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**Release/Obtain the following health information:**

- Labs less than 1 year old
- Imaging Studies less than 1 years old
- Other: MOST RECENT PROGRESS NOTE, IMMUNIZATION HISTORY, AND PATIENT SUMMARY INCLUDING MEDICATION AND PROBLEM LISTS.

**Dates Requested:**

(2 YEARS PRIOR TO DATE

SIGNED BELOW)

**Start date**

(DATE SIGNED BELOW)

**End Date**

**West Cecil Health Center**  
**PO Box 99**  
**Conowingo, MD 21918**  
**Phone: (410) 378-9696 Fax (410) 378-9922**  
**Email: [records@westcecilhealth.org](mailto:records@westcecilhealth.org)**

**Reason for request:**

- Change in provider

**I understand that:**

- WCHC will make every effort to release information in the safest and efficient formats possible and prefers to use encrypted electronic formats. If you request unencrypted email, CDs, and flash drives that are not password protected it is your responsibility to take extra precautions to protect the data on the device. Unencrypted email could be intercepted and seen by others; in addition, there are risks including misaddressed/misdirected messages, shared email accounts, and messages forwarded to others.
- If you have a preferred format indicate so here: 1) [robert.wolf@259802931462148.direct.elationemr.com](mailto:robert.wolf@259802931462148.direct.elationemr.com) 2) Virtru Encryption to [rwolf@wolfmedgroup.com](mailto:rwolf@wolfmedgroup.com) 3) fax to 443-961-9295
- WCHC has 21 days to release my records and will communicate with me if there are any reasons for delay.
- I agree to pay applicable fees for copies of my health record. (*Note: Fees are in alignment with federal and state regulations.*)  
Fees are as follows:
  - Publishing information to the portal: no charge;
  - Electronic transmissions: \$6.50 flat;
  - Paper copies: \$22.88 preparation fee plus \$0.76/page fee and postage
- This authorization is voluntary and will not impact my care or treatment.
- My record may contain information related to: genetic information, substance use, communicable diseases including, but not limited to, HIV, AIDS, and STDs, mental health information, and/or records from other healthcare providers that are part of my WCHC record. This information will be released with my health information unless otherwise specified here: \_\_\_\_\_.
- This authorization is valid for 90 days from the date signed unless I revoke/withdraw the authorization or an earlier date is specified here \_\_\_\_\_. I may revoke/withdraw this authorization, except to the extent that the action has been taken prior to the receipt of the revocation/withdrawal, by mailing or faxing my written request.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- WCHC will deny a request for records if information was obtained from another healthcare provider under a promise of confidentiality or if information compiled is reasonably anticipated for use in a civil, criminal, or administrative action or proceeding.
- WCHC may deny a request for records if the information; in the exercise of professional judgment, is reasonably likely to cause substantial harm to such other person.
- If this request is being made on behalf of a patient, including requests made by a parent, certain elements of the record may not be disclosed based on that relationship including, but not limited to, family planning, STI treatment, substance use and mental health records.

X

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Signature of Patient Date

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Signature of Parent/Legal Guardian/Other Relationship to patient Date

***If you are not the patient but are signing on behalf of the patient you must provide proof of your authority to act on behalf of the patient with exception to a parent.***