

COMMUNITY HOSPITALS & WELLNESS CENTERS 433 W. High Street; Bryan, Ohio 43506-1679 Medical Record Dept. Phone: (419) 630-2107 Medical Record Dept. Fax: (419) 636-1770

How to Request Your Medical Information

(Allow 2 Business Days for Processing)

• Complete the "Authorization for Release of Medical Information" form.

The form is available from:

- CHWC website using the steps below
- picked up at any CHWC facility, or
- faxed/mailed upon request by calling 419-630-2107.

Obtaining the form via hospital website:

- 1. Go to <u>www.chwchospital.org</u>
- 2. Click on "Medical Release Form" located on the left side of the page
- Send Completed form to the Medical Records Department.

Fax:	419-636-1770
Address:	433 W High Street
	Bryan, OH 43506

Or the form can be dropped off at the Registration Desk near the main entrance at one of the following CHWC facilities: Bryan Hospital, Montpelier Hospital, or Archbold Medical Center.

• Pick up your Medical Information by checking in with Admissions at the Bryan Building. Records can be mailed upon request. Identification is needed at the time of pick up; photo ID preferred. Charges may apply.

COMMUNITY HOSPITALS and WELLNESS CENTERS

Montpelier Hospital (CAH) Bryan Hospital Archbold Medical Center

909 E. Snyder Ave. 433 W. High St. 121 Westfield Dr.

Montpelier, OH 43543 Bryan, OH 43506 Archbold, OH 43502

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

FOR OFFICE USE ONLY

Patient Information	Patient Name: Last First Middle Date of Birth:
Release To	Name/Organization:
Purpose	Records are to be released for the following purpose(s): (Select all that apply) Medical Care Attorney/Legal Personal Insurance
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 Other (Specify):
Patient/Parent/Ledgal 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 (or given relationship) 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: Date: Date: Date: Date: Date:
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 Fax the form to: 419-636-1770
For	Office Use Only: Employee #: Request Completed By: Employee #: Released By: Employee #: Witness (Telephone): Employee #: Date/Time Released: Employee #: HPCONSREL1 (Acute Tab Location: Consents/Release/DPAHC/Living Will) CHWC CHART 12/13



(patient label)

Medical Record #: