Alexandra Tran, PA-C
Victoria Hase, PA-C

WESTERN MEDICINE, INC.
Jacob Dean, M.D.

Jennifer Dyer, NP-C
Trent Nourse, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

Records from:

_____

_____

_____

Send to: WESTERN MEDICINE, INC.

Circle one:

Dean Nourse Dyer
Tran Hase

P. O. Box 339

Enon , Ohio 45323

Phone: (937) 864-7363

Fax Number : (937) 864-5895

************* ONLY SEND THE REQUESTED RECORDS BELOW **************

_____ Consult Reports
_____ Immunization Record
_____ Laboratory Results
_____ Radiology Reports
_____ Operative Reports
_____ Emergency /Hospital
_____ Pathology Reports

I understand that information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol / drug (substance) abuse or any such related information.

Description of the purpose of the use and/or disclosure: (check one)

_____ Transfer of Care/Selecting new Physician
_____ Relocating out of town
_____ Attorney / Court Case
_____ Specialist Care
_____ Continuity of Care
_____ Other: (Specify) _____

I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy regulations. I understand Western Medicine, Inc. may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event)

I further understand that I may revoke this authorization at any time by notifying the parties involved. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient Representative — Date

If signed by a representative, state relationship to Patient : _____

LEGAL AUTHORITY : _____
[attach supporting documentation]

To assist you with this request, I am providing you with the following identifying information:

_____ _____
Print Name — Street Address

_____ _____
Date of Birth — Phone # — City — State — Zip Code