COMMUNITY HEALTH SERVICES
410 Birchard Avenue
Fremont, OH 43420

AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

PATIENT NAME:____
LAST FIRST MI MAIDEN OR OTHER

______________________ ______________________ ______________________
DOB SSN MEDICAL RECORD #

______________________ ______________________ ______________________
ADDRESS CITY/STATE ZIP CODE

INFORMATION RELEASED FROM:

____
NAME

____
ADDRESS

____
CITY/STATE/ZIP

INFORMATION RELEASED TO:

____
NAME

____
ADDRESS

____
CITY/STATE/ZIP

INFORMATION TO BE RELEASED OR INSPECTED: (Check all applicable categories.)

_____ Entire Chart/Record, including, but not limited to, all of the following:

___ Immunizations
___ Discharge Summary
___ History & Physical
___ Operative Reports
___ Emergency Room Reports
___ Pharmacy/Prescription
___ Emergency Transport Reports
___ X-ray and Other Radiology Reports
___ Laboratory Reports
___ HIV Related Information
___ Nursing Notes
___ Doctor's Orders and Progress Notes
___ Copies of Reports Originating From Other Providers
___ PT, OT, and/or Speech Therapy Notes
___ Rehab Clinic Reports
___ Mental Health/Alcohol or Drug Abuse Treatment, HIV, and/or AIDS-related Treatment
___ Workers' Compensation
___ Billing and Patient Account Records
___ Social Services Reports and/or Evaluations

___ Other: ____

REASON FOR DISCLOSURE: ____

This authorization will remain in effect for eight (8) months or until _________________ and will be effective for medical records generated up to the date of the signature. I understand that:

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization;
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.

A FAX copy/photocopy of this authorization shall be considered as valid as the original.

______________________________ ______________________________
Signature of Patient Signature of Parent/Guardian/Authorized Person

______________________________ ______________________________
Date Date

Reason Patient Unable to Sign: ___Minor ___Incompetent ___Deceased