



## AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

### PATIENT INFORMATION

PATIENT NAME \_\_\_\_\_ MAIDEN OR OTHER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ADDRESS – CITY, STATE & ZIP \_\_\_\_\_

### INFORMATION RELEASED FROM:

### INFORMATION RELEASED TO:

NAME \_\_\_\_\_ NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY, STATE & ZIP \_\_\_\_\_ CITY, STATE & ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

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

From \_\_\_\_\_ to \_\_\_\_\_ **If no dates listed, we will send only 2 years of information.**  
DATE DATE

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

- |  |   |
|--|---|
| <input type="checkbox"/> Office Notes  | <input type="checkbox"/> Problem List /Medication List                      |
| <input type="checkbox"/> Diagnostic Imaging Reports                          | <input type="checkbox"/> OB/GYN Records                                     |
| <input type="checkbox"/> Laboratory Reports                                  | <input type="checkbox"/> PT, OT, and/or Speech Therapy Notes                |
| <input type="checkbox"/> Emergency Room/Hospital Reports                     | <input type="checkbox"/> Pharmacy/Prescription/Medication Listing           |
| <input type="checkbox"/> Billing and Patient Account Records                 | <input type="checkbox"/> Nursing Home, Home Health, and Hospice Records     |
| <input type="checkbox"/> Appointment Information                             | <input type="checkbox"/> Copies of Reports Originating From Other Providers |
| <input type="checkbox"/> Dental Records                                      | <input type="checkbox"/> Immunizations                                      |
| <input type="checkbox"/> HIV and Communicable Disease Testing (Confidential) | <input type="checkbox"/> Other: _____                                       |

**NOTE: If transferring your medical care to another provider all future appointments will be cancelled.**



REASON FOR DISCLOSURE

**This authorization will remain in effect for one (1) year or until \_\_\_\_\_ and will be effective for medical records generated up to the date of the signature. I understand that:**

1. I may revoke this authorization in writing at any time by notifying the Privacy Officer at 2221 Hayes Avenue, Fremont, Ohio 43420. I also understand that this authorization will cease to be effective on the date notified except to the extent that information has already been released in response to this authorization.
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and the disclosed information is no longer protected by the privacy regulations of the practice.
3. My treatment, payment or eligibility for benefits or enrollment in a health plan may not be conditioned on obtaining this authorization.
4. My refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.
5. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee as established by state or federal guidelines.
6. I am entitled to a copy of this authorization after I have signed it. This copy will be made available to you upon request. A FAX copy/ photocopy of this authorization shall be considered as valid as the original.

PATIENT SIGNATURE

DATE

SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED PERSON

DATE

Reason Patient Unable to Sign:  Minor     Incompetent     Deceased

**Mailing Address: 2221 Hayes Avenue, Fremont, OH 43420**

**Phone: 419-334-3869    Fax: 419-334-8546**

**For Office Use Only (please date and initial)**

\_\_\_\_\_ Put on disk

\_\_\_\_\_ Mailed

\_\_\_\_\_ Faxed

\_\_\_\_\_ Printed & Given

\_\_\_\_\_ Picked Up

\_\_\_\_\_ PHI Request Complete