Authorization for Release of Health Information

Name of Individual/Maiden/AKA if applicable (Last, First, MI) _____ Date of Birth _____ Medical Record Number (if known) _____

Address _____ City _____ State/Zip _____ Phone Number (_____)_____

Health information to be disclosed:

Dates of Service (if known): From_____ To _____

- ☐ Emergency Department
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Complete Medical Record
- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Discharge Summary
- ☐ Office Notes
- ☐ Billing Reports
- ☐ History & Physical
- ☐ EKG
- ☐ Medication Records
- ☐ Research Records
- ☐ Other (Specify in detail):_____

I would like: ☐ To inspect medical records ☐ A copy of medical records

Reason for Disclosure: ☐ At the request of the patient ☐ Other (describe):

This information may be released from:

Organization or health care provider making disclosure _____

Address _____

City _____ State/Zip _____

Phone Number (_____)_____ Fax Number (_____)_____

This information may be disclosed to: ☐ Self

Individual or organization receiving information _____

Address _____

City _____ State/Zip _____

Recipient Phone Number (_____)_____ Recipient Fax Number (_____)_____

I hereby authorize the use or disclosure of personal health information about me as described above. I understand if a request to inspect the record is made, nothing may be removed, taken apart, or noted in or on any portion of the medical record. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such a person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of Aultman, I understand that I may revoke this authorization in writing any time, except to the extent that action has been taken by Aultman in reliance on this authorization, by sending a written revocation to **Aultman Medical Records Department, 2600 Sixth Street SW, Canton, Ohio 44710**. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand this authorization is voluntary and Aultman will not condition treatment, payment, enrollment or eligibility for benefits on this authorization. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and/or Human Immune Virus/Acquired Immune Deficiency Syndrome, or other sensitive information, and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment, HIV test results or diagnosis.

Signature:_____ Date:_____

If the personal representative of the individual is signing this authorization, please attach document(s) of the personal representative's authority to act on behalf of the individual, if any:

Patient Representative's Signature:_____ Date:_____

Description of Authority:_____

For Office Use Only: Pages Released: Date: Initials: