☐ University Hospitals Medical Practices

☐ University Hospitals Medical Group

RECORDS TO BE RELEASED FROM:

Name of Practice: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name

_____

(Please Print) Last First M/I

Date of Birth _____ Social Security Number _____

Address _____ Phone Number (____)_____

_____

_____ Medical Record Number _____

Treatment Date(s)

_____

_____

Please Release Medical Information to the Following Recipient:

Name of Person or Organization _____ Phone # _____

Address _____

Mailstop_____

_____

City State Zip Code

Purpose of Disclosure ☐ at the patient's request

Information Requested (please specify):

___ Office Notes ___ Laboratory Results

___ X-ray results ___ Operative Reports

___ Other – Please specify _____

I, the undersigned, authorize _____ (Disclosing Entity) including its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that Information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Disclosing Entity. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 six months.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of Information and accept financial responsibility.

X _____ _____ / _____ / _____

Signature of Patient/Legal Representative** Date Signed

☐ Patient unable to sign

_____

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.