OhioHealth Primary Care Physicians

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Powell, OH 43065
PH 740-549-7450 Fax 740-549-7454

Authorization for Release of Medical Information

Date: _____

Patient: _____ Date of Birth: _____

Name used when treatment occurred if different than above:_____

From: _____ To: _____

_____ _____

_____ _____

The purpose of the release of information is:

___ Changing Doctor / Moving from Area

___ Insurance of Third Party Reimbursement

___ Pending Legal Action ( ) MVA ( ) SS Claim ( ) Industrial Claim

This authorization specifically pertains to information related to my treatment that occurred on or between _____

Date(s)

I understand that this medical information will contain copies of physician office records for designated date(s) listed above, which pertain to my evaluation and treatment. Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, it is not a condition of treatment. The protected health information released may include information concerning testing, diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), SEXUALLY TRANSMITTED DISEASE, PSYCHIATRIC AND OR DRUG/ALCOHOL TREATMENT that may be in my medical record.

This authorization may be revoked at any time in writing to the office manager of this practice. The revocation will not apply to information that has already been released. This authorization for the release of medical information is valid for 60 days from the date signed below. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Relationship to Patient (if other than the patient) **Witness (if applicable)**