AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name:_____ Birth Date: _____

Address: _____ Phone No: _____

_____ Soc. Sec. #:_____

Send Information to:_____ Phone #: _____

Address: _____ Fax #:_____

_____

I hereby authorize Western Reserve Hospital to release the health information to the recipient named above. I understand that the information in my health record may include information relating to drug/alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C, acquired immunodeficiency (AIDS) or human immunodeficiency virus (HIV), or other sensitive information.

INFORMATION TO BE RELEASED - CHECK ALL THAT APPLY:

_____Pertinent Summary _____Operative Report* _____X-rays*

_____History & Physical* _____Pathology Report* _____Cardiology*

_____Consultation* _____Lab Results* _____Emergency Record*

_____Blood Type _____Discharge Summary*

_____Other:_____

*These documents are included in a pertinent summary

DATES OF SERVICE:_____

PURPOSE or NEED FOR INFORMATION (CHECK ONE):

❒ Continuity of Care Follow Up Care ❒ Legal Insurance ❒ My Personal Files ❒ Other (specify)

I understand that I have the 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 Medical Records Dept. Director. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- This authorization for access or release is valid for 1 (ONE) YEAR from the date of the signature,
- By law, WRH has 30 days to provide copies of records.

**** I am aware there will be a charge for records going to me. I will be prepared to pay for them at time of picking up copies.**

AUTHORIZING SIGNATURE:_____ DATE:_____

Signed by: _____Patient _____Legal Guardian _____Executor of Estate _____Other (specify)

RECORD COPIES: MAIL_____ PICK UP_____ FAX_____ (to Physician Office Only)

I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal privacy laws and regulations. Rev04.03

NUMBER OF PAGES COPIED:_____ I.D. SHOWN: _____ MRD STAFF Initials:_____

1900 23rd Street, Cuyahoga Falls, OH 44223
P: (330) 971-7414 F: (330) 971-7087
westernreservehospital.org

WESTERN RESERVE HOSPITAL
Proudly Physician Owned