| Family Health Services | **Title:** Authorization to Release Medical Records | ID #: MR1000<br>Effective: 12/17/2025<br>Page: 1 |
|---|---|---|
| | PHONE: 419-502-2800 • FAX: 419-502-2821 | |

| **PATIENT NAME:** | **DATE OF BIRTH MM/DD/YYYY:** |
|---|---|

| **I hereby authorize records be obtained FROM:** | **I hereby authorize records to be released TO:** |
|---|---|
| Facility Name: | Facility Name: |
| Street Address: | Street Address |
| City/State/Zip: | City/State/Zip: |
| Phone Number: | Phone Number: |
| Fax Number: | Fax Number: |

Records to be released for treatment dates between: _____ - _____ ☐ Release Any/All Dates

**Types of Information to be released:**

| | | |
|---|---|---|
| ☐ Admission Summary | ☐ Diagnostic Assessment | ☐ Progress Report |
| ☐ IEP/504 Plan | ☐ Discharge Summary | ☐ Medication History |
| ☐ Drug Treatment | ☐ Lab Reports | ☐ Psychological Testing |
| ☐ Behavioral Health/Psychotherapy | ☐ HIV/AIDS Treatment | ☐ Recommendations |
| ☐ Alcohol/Drug Treatment | ☐ ETR/MFE | ☐ Demographic Information |
| ☐ Measured Outcomes | ☐ Financial Eligibility/Public Assistance History | |
| ☐ FERPA/Educational Records (attendance, enrollment, discipline, class schedule and grades) | | |
| ☐ Psychotherapy Notes ONLY (by marking this box, I understand I am waiving any therapist/patient privilege) | | |
| ☐ Other: | | |

I hereby authorize Family Health Services (FHS), its agents and its employees, to release and/or request Protected Health Information about me, my minor child or the patient named above which may include test results, diagnosis, treatment or other information about HIV or other communicable disease, as well as any alcohol and/or drug information and mental health information protected by Federal Regulation (42CFR Part 2). I understand that the information will be used for the purposes of clarifying diagnosis, formulating treatment plans and coordination of care. I understand that information disclosed by this authorization, except for alcohol and/or drug abuse information, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a). This authorization may be revoked by sending a letter to the address below, except if action has been taken in reliance of this authorization. Unless otherwise revoked this authorization is valid for 180 days.

Family Health Services
Attn: Ancillary Department
1912 Hayes Avenue
Sandusky, OH 44870

I understand I am responsible for any fees associated with the copying and releasing of records. I also understand that a photocopy is as valid as the original.

| SIGNATURE OF PATIENT OR RESPONSIBLE PARTY*: | DATE: |
|---|---|
| PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY*: | RELATIONSHIP TO PATIENT: |

*** IF SOMEONE OTHER THAN THE PATIENT IS SIGNING THIS FORM, A COPY OF LEGAL PAPERWORK VERIFYING THE PATIENT'S PERSONAL REPRESENTATIVE MUST ACCOMPANY THE CONSENT (I.E. COURT APPOINTED GUARDIANSHIP OF THE PATIENT OR DURABLE HEALTHCARE POWER OF ATTORNEY). THE ONLY EXCEPTION IS IF A PARENT IS SIGNING FOR A MINOR CHILD.**