Family Health Services

1912 Hayes Avenue
Sandusky, Ohio 44870
Phone: 419-502-2800
Fax: 419-502-2821

# Authorization to Release Medical Records

**PATIENT INFORMATION:**

NAME: _____ DOB: _____ MRN: _____

ADDRESS: _____ SS# _____

**PATIENT INFORMATION IS NEEDED FOR**:

| | | |
|---|---|---|
| Continuing Medical Care | Military | Social Security/Disability |
| Insurance | Personal Care | Other: _____ |
| Legal Purposes | School | _____ |

**INFORMATION TO BE RELEASED OR ACCESSED:**

| | | |
|---|---|---|
| History & Physical | Consultation Report | Emergency Room Record |
| Operative Reports | Discharge/Death Summary | Face Sheet |
| Lab/Path Reports | X-Ray Reports/Images | Other: _____ |

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

| | | |
|---|---|---|
| TO: | **Family Health Services** | **FROM: _____** |
| | **1912 Hayes Ave, Sandusky 44870** | **ADDRESS: _____** |
| | **(419)502-2800** | **PHONE: _____** |
| | **(419)502-2821** | **FAX: _____** |

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected. I understand that the specified drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature _____

Patient or Legally Authorized Representative:

Printed Name: _____ Relationship: _____