Family Health Services

Authorization to Release Medical Records

PATIENT INFORMATION:

NAME: _____ DOB: _____

MRN: _____ SS#: _____

Street Address: _____ City, State & Zip _____

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	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:** _____

(844)766-1828 **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 information to be released may include but is not limited to history, diagnoses, and/or treatment of 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 six (6) 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: _____