

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:

Cleveland		Ahuja □ Bedford □ Conne ichmond □ UH Home Care □				
the state of the s						
(Please Print)	Last	First				M/I
Date of Birth _		Social Security N	√umber	(last four dig	gits)	
Address Phone Number (_ Medical Record N Prior MR #					Number	
Please Release Medical Information to the Following Recipient:  Name of Person or Organization  Address				_ Phone # _ Mailstop _ Fax #		
City				Zip Code		
Purpose of Dis	sclosure					at the patient's request
☐ Pertinent Sur ☐ Admission For ☐ *Discharge \$ ☐ *Emergency ☐ *History & P ☐ *Consultation ☐ *Operative For ☐ Information regards ☐ AIDS-related conditional authorization may be a surple of the sur	nmary (includes all orm  Summary Room Report hysical on Report  Report  authorize from my medical reing psychiatric disorditions, alcohol, and/orm	Facesheet / Demograp Lab Reports *Radiology Report *EKG Report *Pathology Report *Card Cath Report *Cords as described above. I unders, Human Immune Virus (For drug dependence/abuse. I also sure by the recipient and may	cians nderstand	Entire Record Physician's No Other(Discleded and acknowledge and that Informatical actions are considered and that Informatical considered and In	losing Institute that the Immune Detion used o	eficiency Syndrome (AIDS), r disclosed according to this
writing and presen apply to information insurance company authorization will ex-	t my written revocati n that has already be v when the law provi opire on the following	roke this authorization at any tile on to the health information men released in response to this des my insurer with the right to date, event, or condition:ondition, this authorization will to the condition of the condition.	anagemer authorizat contest a	nt department. I lion. I understand a claim under my	understand I that the re r policy. Un	I that the revocation will not vocation will not apply to my
I understand that tr	eatment, payment, e	nrollment, or eligibility for bene	fits will no	t be conditioned	on my failu	re to sign this authorization.
I understand there	may be charges for t	he copying and release of Infor	mation an	nd accept financia	al responsib	pility.
×						/
•		Signature of Patient/Legal F	Representa	ative**		Date Signed
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)					plicable)	☐ Patient unable to sign
By signing this the binding arbitration	form as the patient's on decision or final m	legal representative, I am certi nediation agreement) prohibiting tleases of records authorized b	fying that g me from	there is no court obtaining a copy	order or of	her legal reason (such as a uested records.

<sup>\*\*</sup>If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.