



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:

- Cleveland Medical Center, Ahuja, Bedford, Conneaut, Elyria, Geneva, Geauga, Parma, Portage, Richmond, UH Home Care, UHPS, Samaritan, St. John

Patient Name (Please Print) Last First M/I

Date of Birth Social Security Number (last four digits)

Address Phone Number Medical Record Number Prior MR #

Treatment Date(s)

Please Release Medical Information to the Following Recipient:

Name of Person or Organization Address City State Zip Code Phone # Mailstop Fax #

Purpose of Disclosure at the patient's request

Description of Information to be Released:

- Pertinent Summary, Admission Form, Discharge Summary, Emergency Room Report, History & Physical, Consultation Report, Operative Report, Facesheet / Demographics, Lab Reports, Radiology Report, EKG Report, Pathology Report, Card Cath Report, Physical Therapy, Entire Record, Physician's Notes, Other

Sandusky Pediatricians

I, the undersigned, authorize Sandusky Pediatricians (Disclosing Institution) and its employees to release information from my medical records as described above.

I understand that I have a 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 health information management department.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of information and accept financial responsibility.

X Signature of Patient/Legal Representative\*\* Date Signed

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable) Patient unable to sign

By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records.

\*\*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.