AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:______________________________ SS #:____________________ DOB: __________

Street:____ City: ____________________

State:__________ Zip:__________ Phone:__________________ Email:____________________

Reason for Disclosure: ____

Name of Recipient: ____

Street:____ City: ____________________

State:__________ Zip:__________ Phone:______________________ Fax: ____________________

Dates of Treatments being disclosed: From:______________ To:________________

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

☐ Complete Health Record ☐ Radiology Reports ☐ Discharge Summary ☐ Consultation Reports
☐ History and Physical Exam ☐ Abstract/Pertinent Information ☐ Progress Notes ☐ Laboratory Tests
☐ Emergency Department Record ☐ HIV/AIDS Information ☐ Drug and Alcohol Treatment Information
☐ Other:______________________________

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization expires in 60 days. Otherwise, you may select either of the following expiration events:

☐ 1 year form the date in which, I, or my legal representative, signs this authorization;
☐ upon the happening of the following event:____
(Example: "Upon release of the above records.")

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. I understand that my revocation won't have any affect on any action taken by the organization before they received the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization. I understand that there may be a change for providing me my medical records.

I understand that I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

If signed by the patient's legal representative:

Printed name of representative: ____

Relationship to the patient: ____

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above:
☐ Yes ☐ No

Signature:____ Date:____________________

PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE PATIENT'S RECORD

St. John Medical Center

29000 Center Ridge Road • Westlake, Ohio 44145
440-835-8000

PATIENT LABEL

0073 (4/14) (191481)
MR.RELEASE