



400 Wabash Avenue
Akron, Ohio 44307
330-344-6000

NAME: X _____

DOB: X _____ SS# X _____

TELEPHONE #: X _____

MR# - -

X DATE: _____

X I, the undersigned hereby authorized Akron General Medical Center to the use or disclosure of my health information and dates of service as described below to:

_____ for the purpose of performing professional services and/or discharging their legal and/or contractual obligations or _____

- X Dates of Services: _____
- All Dates of Service

X I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that Akron General Medical Center may require compensation for the use I request before that request will be completed.

This authorization for access or release is valid for sixty (60) days but may be revoked by the patient at any time except to the extent that action has been taken in reliance thereon. I understand and acknowledge that the medical record may contain information regarding **psychiatric disorders, drug/alcohol abuse, HIV test results, a diagnosis or AIDS or an AIDS related condition** and I expressly consent to the release of any such information contained in the records designated above. I agree further that a photocopy of this authorization shall be as effective as the original hereof.

Authorizing Signature: X _____

If other than patient: Parent Guardian

SPECIFIC INFORMATION REQUESTED:

- | | | |
|---|--|--|
| <input type="checkbox"/> ADMISSION FORM | <input type="checkbox"/> EMERGENCY RECORD | <input type="checkbox"/> OTHERS: _____ |
| <input type="checkbox"/> PHYSICIAN ORDERS | <input type="checkbox"/> PROGRESS NOTES | _____ |
| <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> OPERATIVE / PROCEDURE REPORTS | _____ |
| <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> LABORATORY REPORTS | _____ |
| <input type="checkbox"/> CONSULTATION REPORTS | <input type="checkbox"/> HISTORY AND PHYSICAL REPORT | _____ |
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> MEDICATION RECORDS | _____ |
| <input type="checkbox"/> OBSTETRICAL RECORDS | <input type="checkbox"/> ITEMIZED BILLING SUMMARY | _____ |

DISPOSITION OF INFORMATION - FOR OFFICE USE ONLY

- | | |
|--|--|
| <input type="checkbox"/> Reviewed Only | <input type="checkbox"/> Fax To Physician (_____) |
| <input type="checkbox"/> Mail To Person Designated Above | <input type="checkbox"/> To Accompany Transferring Patient |
| <input type="checkbox"/> Give To Person Designated Above | <input type="checkbox"/> Access Denied (See Reverse Side) |
| <input type="checkbox"/> Mail To Physician | |

Completed By: _____ Date: ____/____/____

FOR OFFICE USE ONLY

PAID ON: ____/____/____

METHOD OF PAYMENT: _____

***NOTE: This form is HIPAA compliant**



DT903

ACCESS & AUTHORIZATION FOR RELEASE OF INFORMATION