

**AUTHORIZATION FOR THE RELEASE
OF MEDICAL INFORMATION**

Health Data Services, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

216/444-2640
800/223-2273 ext. 42640
Fax: 216/445-7589

X Patient: _____ SS#: _____
Clinic#: _____ Date of Birth: ____/____/____
Telephone #: _____ Current Address: _____
City: _____ State: _____ Zip: _____

I hereby authorize the Cleveland Clinic to release the health information indicated below that is contained in my patient records to the Recipient named below. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* The release of Psychotherapy Notes requires a separate authorization.**

Name of Recipient: EMSI Telephone: 330-923-8255
(please print)
Street: 654 Portage Trail
City: Cuyahoga Falls, State: OH ZIP: 44221

Reason for Disclosure: Life Insurance
(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment: _____

Please list additional Cleveland Clinic locations if needed:

Emergency Department Reports	Pathology Reports	Cleveland Clinic Family Health Centers (list locations below):
Discharge Summary	Laboratory Reports	,
History & Physical	Radiology Reports	,
EKGs	Operative Reports	,
Physical/Occupational Therapy Reports	Other Specify): _____	,

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.** I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

X _____ X _____ X
Signature of Patient/Patient's Personal Representative** Printed Name Date Signed

Relationship if not Patient

*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.