

AUTHORIZATION TO **RELEASE** PROTECTED HEALTH INFORMATION
TO ANOTHER FACILITY

I hereby grant permission for The MetroHealth System to release a copy of my medical records. **I understand that the information released upon authority of this authorization may contain information concerning treatment for a sexually transmitted disease, alcohol, drug abuse, a psychiatric condition, or HIV test results, an AIDS diagnosis, or AIDS-Related condition.** I further understand authorization does not include permission to release outpatient Psychotherapy notes. The release of Psychotherapy notes requires a separate authorization (Psychotherapy notes are separated from the rest of a patient's medical record).

This authorization is valid for a period of 60 days from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance. The revocation must be provided to the MetroHealth Medical Record Department.

SPECIFIC INFORMATION TO BE RELEASED:

FOR THE PURPOSE OF: _____ At the patient's request.

The copy of the medical record is to be released to:

NAME: **Examination Mgt Svcs Inc**
654 Portage Trail Ste 4
STREET: **Cuyahoga Falls OH 44221**
330-923-8255
CITY/STATE/ZIP/COUNTY: _____

PATIENT NAME: _____ OTHER NAME(S): _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____ SSN: _____ - _____ - _____

MHS MEDICAL RECORD #: _____ TELEPHONE NUMBER: (____) _____

PATIENT'S SIGNATURE: _____ DATE: ____/____/____

My health care (or payment for care) will not be affected by whether or not I sign this authorization. Once my health care information is released, redisclosure of my health care information by the recipient may no longer be protected by law.

Signature of Authorized Representative (Please state relationship)*:

_____(_____) DATE: ____/____/____

*If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney or Death certificate) **MUST** accompany the authorization when presented. Exception: parent is signing for patient under age 18.

NOTE: An incomplete or improper authorization cannot be honored.

[METROHEALTH STAFF ONLY: Request processed or facilitated by: _____ in
(Department Name): _____ at (Facility Name): _____
 Faxed on _____ OR Mailed on: _____
(Date) (Date)