

UniversityHospitals
of Cleveland

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____
(Please Print) Last First M/I

Date of Birth _____ Social Security Number _____

Address _____ Phone Number (____)-_____

Medical Record Number _____

Treatment Date(s) _____

Please Release Medical Information to the Following Recipient:

Name of Person or Organization _____ Phone # _____
Address _____ Mailstop _____

City State Zip Code

Purpose of Disclosure _____ at the patients request

Description of Information to be Released:

- | | | |
|---|--|---|
| <input type="checkbox"/> Pertinent Summary (includes all * items) | <input type="checkbox"/> Facesheet | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Admission Form | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> *Discharge Summary | <input type="checkbox"/> *Radiology Report | <input type="checkbox"/> Other |
| <input type="checkbox"/> *Emergency Room Report | <input type="checkbox"/> *EKG Report | _____ |
| <input type="checkbox"/> *History & Physical | <input type="checkbox"/> *Pathology Report | _____ |
| <input type="checkbox"/> *Consultation Report | <input type="checkbox"/> *Card Cath Report | _____ |
| <input type="checkbox"/> *Operative Report | | |

I the undersigned, authorize _____ (Disclosing Institution) and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

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 the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

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

_____ As a professional courtesy, no cost is assessed for information released directly to your health care provider. All other releases are subject to a reasonable, cost-based fee. 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

X _____ / ____ / ____
Signature of Witness Date Signed