AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I give permission to ______________________ Hospital to

☐ **Release To** ☐ **Receive From**

Name of person/Doctor/Hospital/Facility: ______________________

Street: __________ City: __________ State: __________ Zip: __________

Phone: H ( ) __________ W ( ) __________ Fax: ( ) __________

*****Reason for Disclosure: (Must be completed prior to processing)**

☐ Continuity of Care/Follow Up ☐ Personal Use ☐ Legal ☐ Insurance

☐ Other (specify): ______________________

*****INFORMATION TO BE RELEASED: (Must be completed prior to processing)**

☐ Entire Record ☐ Pertinent Summary Information ☐ History & Physical ☐ EKG

☐ ED Record ☐ Discharge Summary ☐ Operative Report ☐ Pathology Report

☐ Lab Results ☐ Radiology Reports ☐ Physical/Occupational Therapy Reports ☐ Consult Reports

☐ Other (specify): ______________________

***Dates of Treatment: ______________________

Patient Name: __________ Date of Birth: __________ SSN: __________ MRN: __________

Street: __________ City: __________ State: __________ Zip: __________

Phone: H ( ) __________ W ( ) __________ Fax: ( ) __________

I hereby authorize Cleveland Clinic Health System Hospital(s) to release or receive the health care information indicated above that is contained in my patient record. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. This authorization may be revoked at any time by putting the revocation in writing and presenting it to Health Information Services. Any revocation will not apply to information that has already been released in response to this authorization. This authorization and consent will expire one year from the date of authorization written below. Any further disclosure requires the specific written consent of the person to whom it pertains or his/her legal representative; reliance on Cleveland Clinic Health System Hospital(s') authorization for release of relevant information is not sufficient for purposes of redisclosure.

***This authorization for release of information is not valid, according to privacy rule, if the asterisked areas on this authorization form have not been completed.

***Signature of Patient / Legal Guardian / Administrator Executor or Next of Kin (Circle one)	Printed Name	***Date Signed
If patient unable to sign state reason why	Witness	Identification Verified: ☐ Yes ☐ No

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