

1.02 MEDICAL RECORDS RELEASE

I, (Patient Name) _____ DOB: _____ authorize,
Provider Name _____ Phone: _____
Fax: _____ Address: _____

To use and/or disclose my health information as identified below to:

Recipient _____ Phone: _____
Fax: _____ Address: _____

The purpose of this disclosure is:

- At the request of the individual, or
 Other (please list reason) _____
 Completed due to subpoena, guardianship request, expert evaluation, power of attorney request: (Attach documentation received – verify patient signature):

The dates of patient care covered by this Authorization are:

The following information may be released:

- | | |
|--|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Urgent Care Records | <input type="checkbox"/> All Hospital Records |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology/Imaging Records |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Records |
| <input type="checkbox"/> Itemized Billing Statements | <input type="checkbox"/> Cardiology Report |
| <input type="checkbox"/> Cardiology Report | |
| <input type="checkbox"/> Other Records as Specified: | |

The following highly confidential information may be released:

- *HIV/AIDS health information and/or records
 Genetic testing information and/or records
 *Mental health information and/or records
 *Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of How much and what kind of information is to be disclosed.

***Psychotherapy notes:** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

- If the person or entity receiving this information is not a health care provider or health care plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected under other applicable state or federal laws and regulations.
- The person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly for doing so.
- I may revoke this authorization at any time by giving written notice to: Privacy Officer, Northern Ohio Medical Specialist, 3004 Hayes Avenue, Sandusky OH 44870. I understand that a revocation of this authorization is not effective with respect to actions NOMS Healthcare has taken in reliance on this authorization.
- Unless revoked earlier, this authorization will expire 180 days from the date of signing.

Signature of Patient or Legal Representative

Date

Print name of Patient or Legal Representative

Date

If signed by a legal representative, please describe relationship to, and legal authority to act on behalf of, the patient:
