|  |  |
| --- | --- |
| **Records Being Released From:** | **Records Being Released To:** |
| Provider or Group Name: | Provider or Group Name: |
| Address: | Address: |
|  |  |
| Phone Number: | Phone Number: |
| Fax Number: | Fax Number: |

**Authorization for Release of Medical Records**

Dates of Service for Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Transferring records:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following portions of the medical record are being requested:

\_\_ Immunizations only \_\_ Progress Notes

\_\_ Labs \_\_ Mental Health

\_\_ History & Physicals \_\_ X-Ray Reports

\_\_ Medications \_\_ **Entire Medical Record**

\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned patient or legal representative, hereby authorizes the full disclosure of my entire or designated portions of my medical record.

I understand that my decision to sign this form is voluntary, and Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand I may revoke this authorization in writing at any time by following the directions in Provider’s Notice of Privacy Practices, except to the extent that Provider has already acted based on this authorization.

I understand that this authorization shall expire without my express revocation, 60 days from date written below. I understand that the information disclosed under this authorization may no longer be protected by HIPPA privacy regulations and may be subject to re-disclosure by the recipient. A photocopy or facsimile of this form shall be valid as the original.

In accordance with Ohio Revised Code Section 3701.742, a provider may charge for the copying and sending of a medical record. The fees for these services are as follows:

* $3.31 per page (pages 1-10)
* 0.69 cents per page (pages 11-50)
* 0.28 cents per page (pages 51 and higher)
* Actual postage incurred by Healthcare Provider

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE DESCRIBED DISCLOSURE**

Signature of Patient or Legal Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_