AULTMAN

Authorization for Release of Health Information

NOTE: Items 2, 3, 4 and 8 or 9 must be filled in for authorization to be accepted.

NAME OF PATIENT (Last, First, MI) MAIDEN/AKA (if applicable)

ADDRESS OF PATIENT

DATE OF BIRTH PHONE # HEALTHCARE RECORD # (if known)

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Address: _____

3. Specifically describe the health information you are authorizing to be used or disclosed:

☐ ER report(s) ☐ Radiology Report(s) ☐ History & Physical ☐ Discharge Summary
☐ Lab Report(s) ☐ Pathology Report(s) ☐ Operative Report(s) ☐ EKG(s)
☐ Billing Report(s) ☐ Complete Medical Record

Other (specify):_____

4. This information may be disclosed to and used by the following individual or organization:

Address: _____

for the purpose of: _____

5. I understand I have the right to revoke this authorization at any time by giving written notice of my revocation to Aultman Medical Records, 2600 Sixth Street SW, Canton, Ohio 44710. I understand the revocation will not apply to information that has already been released in response to this authorization. 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 one year. An authorization for medical records expires in one year unless a shorter period is stated.

6. I understand this authorization is voluntary and Aultman will not condition treatment, payment, enrollment or eligibility for benefits on this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and/or Human Immune Virus/Acquired Immune Deficiency Syndrome and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment (42 CFR Part2), HIV test results or diagnosis (ORC 3701.243).

7. I have had full opportunity to read and consider the contents of this authorization, I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my health information as described in this form.

8. Patient Signature:_____Date: _____

Witness: _____Date: _____

9. If the personal representative of the individual is signing this authorization, please attach document(s) which support the personal representative's authority to act on behalf of the individual, if any:

Personal Representative's Signature:_____ Date: _____

Description of authority: _____