Ghent Family Practice, Inc.
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Akron, OH 44333
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Name:________________________________
DOB:__________SS#____________________
Telephone:___________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned on behalf of :____,
(Name of Patient)

hereby authorize: ____
(Health Care Facility you want records from)

to release to:____
(Health Care Facility you want records sent to)

____
(Address)

For the purpose of performing professional services for the above named patient and/or discharging their legal and/or contractual obligations or continuity of care the following information checked below which has been requested regarding the diagnosis and treatment of the patient on the following dates: ____.

Reason for records transfer?____

This authorization for release of information is valid for sixty (60) days but may be revoked by the patient/client at any time except to the extent that action has been taken in reliance thereon.

According to House Bill 508, effective March 22, 2001, medical practices are able to charge for copying medical records. This Bill established the following fees: $15.00 Research Fee. $1.00 per page for first 10 pages. 50¢ per page for pages 11-50. 20¢ per page for 51 or higher pages. Cost of postage may be charged.

I understand and acknowledge that the medical record may contain information regarding psychiatric disorder, drug/alcohol abuse, HIV test results, a diagnosis of AIDS or an AIDS related condition and I expressly consent to the release of such information contained in the records designated above.

I agree further that a photo copy of this authorization shall be as effective as the original hereof.

Authorizing Signature:____on ____/____/_____
Signed by: ☐Patient ☐Parent ☐Guardian ☐Other (explain):______________________________

Witness Signature:____

SPECIFIC INFORMATION REQUESTED:

☐Lab Reports	☐Radiology Reports	☐History and Physical
☐Progress Notes	☐EEG/ECG Reports	☐Radiology Reports
☐Obstetrical Record	☐Progress Notes	☐Clinical Sheets
☐Emergency Room Report	☐Medications and Treatments	☐All Records

DISPOSITION OF COPIES—MEDICAL RECORD USE ONLY

Records REVIEWED and/or COPIES received by:_____________________________________

☐REVIEWED only, no copies prepared	☐To ACCOMPANY transferring patient
☐MAIL to facility or person designated above	☐PATIENT to transport as per Doctor's orders
☐To be GIVEN to person designated above	☐Other:__________________________________