4139 Boardman-Canfield Rd
Canfield, OH 44406
PH 330.702.1281
FAX 330.702.1287

MEDICAL RECORDS RELEASE

Patient Name _____ Date of Birth _____

Patient's Maiden Name _____ Telephone _____

Patient's Address _____

Please release my medical records FROM:

Name: _____

Address: _____

_____

Fax #: _____

Please release my medical records TO:

Name: _____

Address: _____

_____

Fax #: _____

DATES OF SERVICE (CHECK ONE AND COMPLETE DATES OF SERVICE IF REQUIRED)

- ❑ Please provide a complete copy of my file for all dates of service
- ❑ Please provide a complete copy of my file for service from _____ through _____

RECORDS TO BE RELEASED:

- ❑ All Records
- ❑ Office Notes
- ❑ Operative Report
- ❑ Radiology Reports/Images
- ❑ Pathology Reports

PURPOSE FOR DISCLOSURE:

- ❑ Patient Request
- ❑ Disability
- ❑ Continuity of Care
- ❑ Legal Review
- ❑ Other _____

PLEASE INDICATE YOUR ACCEPTANCE BY CHECKING THE FOLLOWING BOXES:

- ❑ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization.
- ❑ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
- ❑ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (Hiv) and Acquired Immune Deficiency Syndrome (AIDS)

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date _____ Signature of patient or legally authorized representative _____

Printed name of patient or legally authorized representative _____