



Internal Medicine and Pediatrics
 "Care" for the whole family
 (614) 864-6010
 Toll Free: 866-877-1757
 Fax: (614) 864-0306

5969 E. Broad Street . Suite 200 . Columbus, Ohio . 43213-1546

AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION AS IT RELATES TO MY CARE TO AND FROM THE PARTIES LISTED BELOW:

TO DR.: _____ FROM DR.: _____

@ _____ @ _____

THE PURPOSE OF RELEASE (CHECK APPLICABLE PURPOSE)

- _____ TO PROVIDE CONTINUITY OF CARE
- _____ INSURANCE OR OTHER THIRD PARTY
- _____ PERSONAL
- _____ WORKER'S COMPENSATION
- _____ LEGAL
- _____ OTHER: _____

INFORMATION TO BE RELEASED (CHECK ALL APPLICABLE)

- _____ ALL INFORMATION INCLUDING HIV/AIDS, MENTAL ILLNESS AND DRUG/ALCOHOL ABUSE.
- _____ ALL INFORMATION EXCLUDING HIV/AIDS, MENTAL ILLNESS AND DRUG/ALCOHOL ABUSE.
- _____ IMMUNIZATION RECORDS
- _____ XRAY/CARDIOLOGY REPORTS
- _____ LAB REPORTS
- _____ OTHER

RECORDS FROM THE TIME PERIOD ____/____/____ THROUGH ____/____/____

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID FOR ONE YEAR. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANYTIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. I UNDERSTAND THAT THERE WILL BE A PRE-PAYMENT FEE FOR THE TRANSFERRING OF RECORDS.

PATIENT'S SIGNATURE: _____ DATE: _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____ DATE: _____

INITIALS OF STAFF: _____