

Canyon
Medical Center Inc.

**Patient Request
Record Release**

5969 E. Broad St. ste 200
Columbus, Ohio 43213

Date _____

Records To Be Received From:

Name of doctor or facility _____

Address _____

City, State, Zip _____

I hereby authorize the above clinical professional staff to release medical
Information contained in _____
(Print Name)

Date of Birth _____ Social Security number _____

Medical Records:

Information to be sent: _____ All Records _____ Specific Records
(Check One) _____

Send Records To:

Canyon Medical Center, Inc.
5969 East Broad St. Suite 200
Columbus, Ohio 43213
Phone: 614-864-6010
Fax: 614-864-0306

Reason for transfer _____

I understand and acknowledge that this authorization extend to all or any part of the records designated
above, which may in clued treatment of physical and mental illness, and/ or may include the results of an
HIV test of the fact that an HIV test was performed. I expressly consent to release the information as
designated above.

Signature of patient or guardian

Signature of witness

This information has been disclosed to you from records, whose confidentiality is protected by Federal Law 42 CFR,
part 2, which prohibits you from making any further disclosure of it without the specific written consent of the person to
whom it pertains, or as otherwise permitted, by such regulations. A general authorization for the release of medical or
other information is NOT sufficient for this purpose.