

# Fairfield Medical Center

## AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL INFORMATION

Medical Information Services  
401 N. Ewing Street  
Lancaster, OH 43130  
Phone (740) 687-8053 Fax (740) 687-8935

### IMPORTANT MESSAGE – PLEASE READ:

Charges may apply to this request. Allow 7-30 working days after completion of Medical Record.  
All medical records will be mailed unless otherwise specified.

Name:	Release To:
Date of Birth:	Address:
Social Security Number:	Phone #:

### AUTHORIZATION

I hereby authorize \_\_\_\_\_ to permit \_\_\_\_\_  
To examine and/or receive a copy of medical records pertaining to Medical History, Mental or Physical Condition, Services Rendered, or Treatment (including but not limited to records of Drug and/or Alcohol Abuse or Psychiatric Treatment, HIV Testing and/or AIDS/ARC diagnosis and/or related conditions, and STD testing and/or treatment.)

### USE

- For My Own Records  
 Social Security/Disability  
 Pursuant to Legal Action  
 Continuity of Patient Care/To Take To My Doctor  
 Insurance/Third Party Reimbursement  
 Other (Specify): \_\_\_\_\_

### DATES

Dates of Service: \_\_\_\_\_

### INFORMATION REQUESTED

- Face Sheet  
 History & Physical  
 Discharge Summary  
 Consultation Reports  
 Radiology Reports  
 Laboratory Reports  
 Operative Reports  
 Pathology Reports  
 Progress Notes  
 Therapy Reports  
 Emergency Room Reports  
 Other specified here: \_\_\_\_\_

### DURATION

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire 1 year from the date of signature and will only be valid for the records dated prior to the date of signature.

### RESTRICTIONS/ REQUIREMENTS

I understand that the information described above may be redisclosed by the recipient if the information is kept as part of their record of treatment. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. In addition, any information received by Fairfield Medical Center from another facility/physician by way of a signed authorization may be redisclosed as part of our record of treatment unless otherwise specified.

I have been informed that certain situations may arise that requires my medical information to be faxed. This would include all types of information including drug/alcohol, psychotherapy notes or HIV related information dependent upon request.

I have been informed of any applicable processing fee upon signing this authorization as well as a required photo ID upon picking up the copies. \_\_\_\_\_ Pt. Initials

### SIGNATURE

Patient's Signature:	Date:
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### RELATIONSHIP

(If other than patient)

- Executor of Estate  
 Legal Guardian  
 Next of Kin  
 Witness  
 Parent  
 Other \_\_\_\_\_

Signature:	Date:
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Was picture ID used to verify requestor?  Yes  No \_\_\_\_\_ ROI Initials



AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL INFORMATION