Fairfield Medical Center

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF MEDICAL INFORMATION

MR #
ACCT #

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.

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

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.

I understand this authorization may include but is not limited to records of Drug and/or Alcohol Abuse, Psychiatric Treatment, HIV testing and/or AIDS/ARC diagnosis and/or related conditions, and STD testing and/or treatment. _____Pt. Initials

USE

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

DATES

Dates of Service:_____

INFORMATION REQUESTED

- ☐ Itemized Bill
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ EKG
- ☐ Echo
- ☐ CD (Cath, Imaging)
- ☐ Emergency Room Reports
- ☐ Isolation Clearance Documentation
- ☐ 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 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:**	**Time:**

RELATIONSHIP
(If other than patient)

- ☐ Executor of Estate
- ☐ Death Certificate Informant
- ☐ Parent (if minor)
- ☐ Legal Guardian
- ☐ Witness

Signature:	**Date:**	**Time:**

Was picture ID used to verify requestor? ☐ Yes ☐ No _____ROI Initials