

Fairfield Medical Center/Fairfield Healthcare Professionals
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:
Request Records from (please circle one): Fairfield Medical Center or Fairfield Healthcare Professionals	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

- | | |
|---|--|
| <input type="checkbox"/> For My Own Records | <input type="checkbox"/> Continuity of Patient Care/To Take To My Doctor |
| <input type="checkbox"/> Social Security/Disability | <input type="checkbox"/> Insurance/Third Party Reimbursement |
| <input type="checkbox"/> Pursuant to Legal Action | <input type="checkbox"/> Other (Specify): _____ |

DATES

Dates of Service: _____

INFORMATION REQUESTED

- | | | |
|---|---|--|
| <input type="checkbox"/> Itemized Bill | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> CD (Cath, Imaging) |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Emergency Room Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Isolation Clearance Documentation |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> EKG | <input type="checkbox"/> Other specified here: _____ |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Echo | _____ |

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:
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RELATIONSHIP
 (If other than patient)

- | | | |
|---|--|--|
| <input type="checkbox"/> Executor of Estate | <input type="checkbox"/> Death Certificate Informant | <input type="checkbox"/> Parent (if minor) |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Witness | |

Signature:	Date:	Time:
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Was picture ID used to verify requestor? Yes No _____ROI Initials

