Authorization for Release of Health Information

____________________ Name of Individual/Maiden/AKA if applicable (Last, First, MI)
____________________ Date of Birth
____________________ Medical Record Number (if known)

____________________ Address ______ City ______ State/Zip (_____)__________ Phone Number

Health Information to be Disclosed:

Dates of Service (if known): From ________________To ________________

☐ Emergency Department ☐ Radiology Reports ☐ Operative Reports ☐ Complete Medical Record
☐ Lab Reports ☐ Pathology Reports ☐ Discharge Summary ☐ Office Notes
☐ Billing Reports ☐ History & Physical ☐ EKG ☐Medication Records
☐ Research Records ☐Other (Specify in detail):

I would like: ☐ To inspect medical records ☐ A copy of medical records: ☐ Mail ☐ Will pick-up ☐ Other:__________

Reason for Disclosure: ☐ At the request of the patient ☐ Other (describe):
Continuity of Care Transfer of Care

This information may be released from:

My Community Health Center
Organization or health care provider making disclosure

2600 Seventh St SW
Address

Canton, OH 44710
City State/Zip

330-363-6242 330-453-4263
Phone Number Fax Number

This information may be disclosed to: ☐ Self ☐ Other

____
Individual or organization receiving information

____
Address

____
City State/Zip

____
Recipient Phone Number Recipient Fax Number

I hereby authorize the use or disclosure of personal health information about me as described above. I understand if a request to inspect the record is made, nothing may be removed, taken apart, or noted in or on any portion of the medical record. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such a person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of MCHC, I understand that I may revoke this authorization in writing any time, except to the extent that action has been taken by MCHC in reliance on this authorization, by sending a written revocation to **My Community Health Center, 2600 Seventh Street SW, Canton, Ohio 44710**. Unless otherwise revoked, this authorization will expire on the following date, event or condition:______________________________. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand this authorization is voluntary and MCHC will not condition treatment, payment, enrollment or eligibility for benefits on this authorization. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and/or Human Immune Virus/Acquired Immune Deficiency Syndrome, or other sensitive information, and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment, HIV test results or diagnosis.

Signature:____ Date:____________________

If the personal representative of the individual is signing this authorization, please attach document(s) of the personal representative's authority to act on behalf of the individual, if any:

Patient Representative's Signature:______________________________ Date:____________________

Description of Authority:____

For Office Use Only: Pages Released: Date: Initials: