

Robinson Memorial Hospital

AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

Health Information Management Department
6847 North Chestnut Street
Ravenna, Ohio 44266
330-297-2560
Fax: 330-297-2309

For Facility Use Only

Log #: _____

MR#: _____

Patient Name _____
(Please Print) Last First Middle Maiden Name

Date of Birth _____ Social Security # _____ Phone _____

Address _____
Street City State Zip

The undersigned authorizes the disclosure of the above named individual's health information from Robinson Memorial Hospital as described below. I understand that the information in my health record may include information regarding emotional illness, drug or alcohol abuse, and HIV (AIDS/ARC) test results.

Release Medical Information To: _____ Phone No. _____
Name of Person/Doctor/Hospital

Method of release:

Fax #: _____ (to physician office only)

Pick Up (requires ID)

Mail: Address _____
Street City State Zip

Purpose of Disclosure:

Continuity of Care/Treatment Insurance Claim Legal My Personal Records Other (specify) _____
(fees apply if not sent directly to a healthcare provider)

Type of information to be used or disclosed:

History & Physical Cardiac Cath Reports Discharge Summary Lab Reports
 Consultation Reports EKG Report Pathology Reports Radiology Reports
 Emergency Room Report Operative Reports Entire Record Other _____

Treatment date(s) _____

As described in our Notice of Privacy Practices, this authorization can be revoked by me at any time in writing except to the extent that the disclosure has already occurred in reliance on this authorization. This authorization is valid for one year, unless specified otherwise. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Signature of Patient / Patient's Personal Representative** Printed Name Date Signed

Relationship if not patient: _____

****If this authorization is signed by anyone other than the patient, indicate the basis of authority and provide documented evidence of such authority. Exception: parent is signing for patient under age 18.**