FIRELANDS Regional Medical Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____
(Please Print) Last First M/I
Date of Birth:_____ Social Security Number (last four digits): _____
Address:_____ Phone Number: (_____) - _____
_____ Medical Record Number: _____
_____

Please Release Medical Information to the Following Recipient:

Name of Person or Organization: _____ Phone #_____
Address: _____ Mailstop _____
_____ Fax# _____
City State Zip Code

Purpose of Disclosure:_____ ❑at the patient's request

Description of Information to be Released:

Treatment Date(s)_____

❑Pertinent Summary (includes all * items)

❑Admission Form	❑Facesheet / Demographics	❑Physical Therapy	❑Chemical Dependency
❑***Discharge Summary**	❑Lab Reports	❑Entire Record	
❑***Emergency Room Report**	❑***Radiology Report**	❑Physician's Notes	
❑***History & Physical**	❑***EKG Report**	❑Other: _____	
❑***Consultation Report**	❑***Pathology Report**	_____	
❑***Operative Report**	❑***Cardiac Catheterization Report**	_____	

I, the undersigned, authorize Firelands Regional Medical Center (Disclosing Institution) and its employees to release Information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immunodeficiency Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization. I understand there may be charges for the copying and release of Information and I accept financial responsibility.

X _____ _____ ___ / ____ / _____
Signature of Patient/Legal Representative** Date Signed

_____ ❑Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

❑By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records.
This box must be checked for ALL releases of records authorized by legal representatives.

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.

(OFFICE USE ONLY) Proof of Identity: _____ _____ _____