Geauga Family Physicisan, Inc.

Authorization To Disclose Health Information

1. Patient Information

Name *(First, Middle, Last)* :	Medical Record/Account Number:
Current Street Address:	City: State: Zip:
Last 4 digits Social Security Number: Date of Birth:	Phone Number

Please indicate from which address you would like to release information (FROM) and to whom it will be sent (TO).

2. CHECK ONE: ◯ **FROM** ◯ **TO**

3. CHECK ONE: ◯ **FROM** ◯ **TO**

Geauga Family Physicians, Inc. **Board Certified Physicians** **J. Brad Moritz, MD John Urbancic, MD Melanie Carlson, MD** **13221 Ravenna Rd. Ste #8** **Chardon, OH 44024** **Phone: (440) 286-6155 Fax: (440)286-6156**	Physician/Facility Name, Mailing Address, Phone & Fax numbers:

Purpose Of Disclosure:_____

(Purpose for disclosue must be completed prior to processing- e.g., continuing care, personal use, legal etc.)

Dates of service to release (From): _____ (To):_____

4. Items to include:

Office Visists ____ ED/Hosp Reports ____ D/C summeries _____ Operative Reports ____ H&P ____

Cardiac Reports _____ Lab Results ____ Radiology Reports ____ PT/OT Reports ____ Oncology Records ____

Other_____

I, the undersigned, authorize the release of health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This Authorization does not include permission to release outpatient Psychotherapy Notes; a release of Psychotherapy Notes or treatment requires a seperate authorization.**

This authorization and consent will expire one (1) year from the date of this authorization, unless revoked by me (or my legal representative) through written notice presented to Geauga Family Physicians, INC. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on wheater or not I sign this authorization.

After my health infomration is released, my inforamtion may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete; signed and dated, it may be returned and result in my information not being released until completed.

Printed Name of Patient: **Printed Name of Patient Representative:**

Signature of Patient/Patient's Representative: **Date:**

/ /