

**AUTHORIZATION FOR RELEASE OF
MEDICAL INFORMATION**



1141 N. Monroe Drive
Xenia, Ohio 45385

(937) 352-2000
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I hereby grant my permission for release of an/or copying of the medical information checked below between the following parties:

FROM: _____ TO: _____

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not effect my ability to obtain treatment. I understand this authorization shall remain in effect for 60 days for med/surg/HIV services and 180 days for Behavioral Services from the date of my signature below unless I specify an earlier expiration date in this space _____. I understand, also, that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved.

It is my desire that only the information indicated below is to be released as a result of this authorization:

- | | |
|--|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Emergency Room Treatment |
| <input type="checkbox"/> HIV/ARC/AIDS | <input type="checkbox"/> Psychosocial Assessment |
| <input type="checkbox"/> Drug/Alcohol Related | <input type="checkbox"/> Social Worker Treatment Notes |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Other-Please Specify _____ |
| <input type="checkbox"/> Psychological Treatment Notes | |

To assist you, I am providing the following identifying date:

 (Patient's Name at the Time of Treatment) (Date of Birth)

 (Date of Treatment-Please specify IP, ER, OP, Etc.) (Social Security Number)

Purpose for Disclosure: _____

 (Signature of Patient/Legal Guardian-Specify Relationship) (Date) (Witness)

ATTENDING PHYSICIAN CONTACTED: _____ YES _____ NO _____ DATE: _____