The Toledo Clinic

Authorization For Use or Disclosure of Medical Records Information

4235 Secor Road

Toledo, OH 43623

Patient Information:

Patient Name_____ **Date of Birth**_____

Last 4 numbers of Social Security #- _____**Maiden/Other Name**_____

Patient Address_____

Phone Number (H)_____**(C)**_____**(W)** _____

Release Information From:

I hereby Authorize the below physician/facility to release my medical records information:

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:**_____ **Fax:** _____

Release Information To:

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Fax:** _____

Specific dates of service to be released: _____

Records to be released: (check option below)

___ Physician Office Pertinent Transfer Package (standard two years of information)

___ Progress Notes ___ Laboratory/Path Results ___ Radiology Results ___ Immunization Record

___Other: please be specific, include dates or testing needed._____

*Note you could be invoiced at the allowable OH Stature rate

By **signing** I understand that the information in my healthy records may include information relating to sexually transmitted diseases, acquire immune deficiency syndrome (AIDS), or human immune deficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

This consent is valid for 90 days from the date of signature unless revoked by me in writing before release of information as designed above. A copy of this authorization, including the following disclosure statement, will be furnished to whom the information is to be released. This information has been disclosed to you from confidential records from disclosure by state law. You shall make no further disclosure of this information without specific written and informed release of the individual to whom it pertains, or as otherwise permitted by state law.

_____ _____

Signature of Patient **Date**

_____ _____

Parent/Legally Recognized Representative Signature** **Date**

**If you are the legally recognized representative of the patient you must provide supporting documentation.