GE Family Wellness Center
Managed by TriHealth

Medical Records Release Request

DATE: _____

SEND TO: GE Family Wellness Center
C/o Queen City Physicians
Attn: Bridgett Taite-Patterson
2753 Erie Avenue
Cincinnati, Ohio 45208
Fax: 513-853-8998

I, the undersigned, hereby authorize to release the following information from my MEDICAL RECORDS. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions, sickle cell anemia, AIDS, AIDS-related complex (ARC) and HIV antibody testing. Review of records is also authorized.

- ❒ Discharge Summary
- ❒ Progress Notes
- ❒ History & Physicals
- ❒ Consultation Report(s)
- ❒ Operative Report(s) & Findings
- ❒ Pathology Report(s)
- ❒ Reports of Tests & X-rays
- ❒ Emergency Treatment(s)
- ❒ Diagnostic Imaging
- ❒ Immunizations (shot) record
- ❒ ALL RECORDS
- ❒ Other: _____

DATES OF TREATMENT: FROM _____ TO _____

The above information is to come from:

_____

_____

_____

The information disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act Privacy/Confidentiality Requirements.

I understand the following:

a. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
b. I have a right to obtain a copy of this authorization.
c. The information released in response to this authorization may be re-disclosed to other parties.

This statement must be signed and dated, and may be revoked in writing at any time except to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below:

Patient's Name (Please Print) _____ Date of Birth _____

Parent's Names _____ Or Legal Guardian _____

Address _____ City _____ State _____ Zip Code _____

Reason for Record Release _____

Patient's Signature (Parent if under age 18) _____ Phone Number _____