

Medical Records Release Request

DATE: _____

SEND TO: GE Family Wellness Center
Attention: Medical Records
P.O. Box 15868
Cincinnati, OH 45215-0868

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.

- | | |
|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Reports of Tests & X-rays |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Emergency Treatment(s) |
| <input type="checkbox"/> History & Physicals | <input type="checkbox"/> Diagnostic Imaging |
| <input type="checkbox"/> Consultation Report(s) | <input type="checkbox"/> Immunizations (shot) record |
| <input type="checkbox"/> Operative Report(s) & Findings | <input type="checkbox"/> ALL RECORDS |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> 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

