ASHTABULA COUNTY MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Ashtabula County Medical Center
Health Information Services Dept.
2420 Lake Avenue
Ashtabula, Ohio 44004

Hospital Phone - (440) 997-2262 ext. 2163
Hospital Fax - (440) 997-6499
Clinic Phone - (440) 997-6911
Clinic Fax - (440) 997-6988

1. Subject Name: ______________________________ SS# ____________
   LAST FIRST MIDDLE

   Date of Birth: ____________ Address ____________________ Phone # ____________

2. I Authorize Ashtabula County Medical Center to release information to:

   Name of Recipient: ____________________ Phone # ____________

   Address: ____

   ____

OR

I authorize Ashtabula County Medical Center (the recipient) to receive information from:

Name: ____________________ Phone # ____________

Address: ____________________ Fax # ____________

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3. Date(s) of Service (Month, Day and Year to the best of your knowledge) ____________________

4. Type of Information to be Released

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Emergency Department Record
- ☐ Hospital Bill
- ☐ Other (please specify) ____________________
- ☐ Laboratory Reports
- ☐ Cardiac Services Reports
- ☐ Clinic Notes
- ☐ **Cardiac Cath Lab**
- ☐ Digital Media

Diagnostic Imaging

- ☐ **Radiology**
- ☐ CT
- ☐ U/S
- ☐ MRI
- ☐ Nuc Med
- ☐ Bone Density
- ☐ Mammo

5. Reason for Disclosure ____
   (Reason for disclosure must be completed prior to processing)

I hereby authorize the release of the health information indicated above that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes (*) as defined below. The release of Psychotherapy Notes requires a separate authorization.
***Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.**

This consent is subject to revocation at any time except to the extent the action has been taken thereon.

This authorization and consent will expire in one year from the date of authorization written below.

I understand that the Recipient of my health information may be charged for the service of releasing medical information.

Your health care (or payment for care) will not be affected by whether you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

A photocopy or facsimile of this authorization will have the same authority as the original.

6. ____________________ / ____________________ ______/______/______
   *Signature of Patient/Legal Guardian*** *Printed Name* *Date Signed*

   ____
   Relationship if not Patient

***If other than patient's signature, a copy of legal papers verifying authority (e.g. Power of Attorney or Death Certificate) MUST accompany the authorization when presented. Exception: Parent is signing for patient under the age of 18.*