Ashtabula County Medical Center
ACMC Healthcare System

An affiliate of
Cleveland Clinic

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Information:		
Name *(First, Middle, Last)*		Medical Record #
Current Address		City State Zip
Last 4 Digits of Social Security #	Email	Phone Number ( ) Date of Birth / /

2. Release Information From:		**3. Release Information To:**	
Name of Facility		Name of Recipient	
Address City/State Zip		Address City/State Zip	
Phone Number ( )	Fax Number ( )	Phone Number ( )	Fax Number ( )

* for release of records from other Cleveland Clinic facilities, you must request directly from the Cleveland Clinic.

Purpose for Disclosure: _____
(Purpose for disclosure must be completed prior to processing. e.g., continuing care, personal use, legal)

Dates of Service to Release (FROM): _____ **(TO):** _____

Type of Information to be Released:

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

Diagnostic Imaging

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

☐ Other (please specify) _____

I, the undersigned, authorize ACMC to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.
If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____ / _____ _____ / _____ / _____
*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____
Relationship, if not Patient

**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 records.*
***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*
***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

For Hospital Records:
(1) Health Information Management
2420 Lake Ave.
Ashtabula, OH 44004
(2) Fax: 440-997-6499
Phone: 440-997-2262 ext. 2163

For Clinic Records:
(3) The Ashtabula Clinic
2422 Lake Ave.
Ashtabula, OH 44004
(4) Fax: 440-997-6988
Phone: 440-997-6911

* ED Phone: 440-997-6637 / ED Fax: 440-997-6498