WRH Physicians, Inc.

1900 23rd St Cuyahoga Falls, Oh 44223

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____ **Birth Date:** _____

Address: _____ **Phone No:**_____

_____ **Soc. Sec. #::**_____

Send Information to:_____ **Phone #:**_____

Address: _____ **Fax #:** _____

_____

I hereby authorize Western Reserve Hospital Physician's Inc. to release the health information to the recipient named above. I understand that the information in my health record may include information relating to drug/alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV), or other sensitive information.

INFORMATION TO BE RELEASED - CHECK ALL THAT APPLY:

_____ Physician Notes **_____Procedure Report** **_____X-rays**

_____ History & Physical **_____Pathology Report** **_____ Cardiology**

_____Lab Results

_____Other:_____

DATES OF SERVICE: _____

PURPOSE or NEED FOR INFORMATION (CHECK ONE):

	Continuity of Care Follow Up Care		**Legal Insurance**		**My Personal Files**		**Other (specify)**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to WRH Physician's, Inc. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- **This authorization for access or release is valid for 1 (ONE) YEAR from the date of the signature,**
- **By law WRH Physician's has 30 days to provide copies of records.**

**** I am aware there may be a charge for records going to me. I will be prepared to pay for them at time of picking up copies.**

AUTHORIZING SIGNATURE:_____**DATE**_____
Signed by: ____Patient ____ Legal Guardian ____Executor of Estate ____Other (specify)_____

RECORD COPIES: MAIL_____ PICK UP _____ FAX _____ (to Physician Office Only)

I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal privacy laws and regulations. Rev04.03

NUMBER OF PAGES COPIED: _____ **I.D. SHOWN:** _____ **STAFF Initials**_____