



AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Will expire in one year if not otherwise specified

PATIENT NAME	LAST	FIRST	MIDDLE
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
<input type="checkbox"/> Summa Health System Medical Records / ROI 525 East Market Street Akron, OH 44309		<input type="checkbox"/> Summa Barberton Hospital Prior to 05/31/15 Medical Records / ROI 155 Fifth Street NE Barberton, OH 44203	
<input type="checkbox"/> Summa Health Center at Wadsworth-Rittman Prior to 07/14/14 Medical Records / ROI 195 Wadsworth Road Wadsworth, OH 44281			
RELEASE TO: <i>(Name of Person or Organization)</i>			
NAME			
STREET		CITY	STATE ZIP CODE

FOR THE FOLLOWING DATES OF SERVICE / TREATMENT: _____

PURPOSE OF DISCLOSURE

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Billing | <input type="checkbox"/> Research |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Fund Raising |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Marketing |
| <input type="checkbox"/> Health Care | <input type="checkbox"/> Other _____ |

Released by: _____
(initials)

- Jump drive
- CD
- Paper

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence /abuse.

I understand that I am not required to sign this authorization form and that the health care provider named above will not condition the provision of treatment or payment to me on the signing of this authorization, except that the health care provider named above may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. The health care provider named above may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal regulations.

I understand that I may revoke this authorization at any time by notifying the health care provider named above in writing, except to the extent that 1) action has been taken in reliance on this authorization; or 2) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

INFORMATION TO BE RELEASED:

<input type="checkbox"/> Pertinent Summary (includes all *items below if contained in the record)		
<input type="checkbox"/> Admission Form <input type="checkbox"/> *Facesheet <input type="checkbox"/> *Discharge Summary <input type="checkbox"/> *Emergency Room Report <input type="checkbox"/> *History & Physical <input type="checkbox"/> *Consultation Record <input type="checkbox"/> *Operative Report	<input type="checkbox"/> *Special Procedure <input type="checkbox"/> *Pathology report <input type="checkbox"/> *Cardiac Cath Report <input type="checkbox"/> *Lab Reports <input type="checkbox"/> *Radiology Report <input type="checkbox"/> *EKG Report <input type="checkbox"/> *EEG Report	<input type="checkbox"/> Respiratory Report <input type="checkbox"/> Medications / treatment report <input type="checkbox"/> Nurses Notes <input type="checkbox"/> Entire Record <input type="checkbox"/> Other _____

SIGNATURE OF PATIENT

DATE

PRINTED NAME OF LEGAL REPRESENTATIVE

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE

DATE

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Guardian | <input type="checkbox"/> POA |
| <input type="checkbox"/> Executor | <input type="checkbox"/> Person Responsible for Estate |

