AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME ____ **Date of Birth**______________
Last **First** **MI**

Address____ **Phone**______________

Release records TO and/or FROM:

Name/Dept:______________________________ Phone:______________ Fax:______________

☐ ***Release TO*** ☐ ***Release FROM*** ***the following Person(s) or Organizations:***

*Name:*____

*Address:*____
_
Street City State Zip

*Phone:*______________________________ *Fax:*______________________________

Person or Place that is requesting records:

☐ Patient/Parent/Guardian ☐ Doctor/Hospital ☐ Lawyer ☐ Insurance Company ☐ Other______________________

Reason records are needed:

☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☐ Legal ☐ Other______________________

Release the records checked below, ☐ Verbally ☐ Written ☐ Electronically(if available)

☐ Visit/Discharge ☐ Lab results
☐ Chart Summary ☐ X-Ray/Film report
☐ Emergency room report ☐ Doctor's office report (Doctor Name______________)
☐ Vaccination (shot) record ☐ Entire Chart
☐ Pathology report ☐ Surgery report
☐ Billing report ☐ Other:______________________________

Treatment Dates:____

This authorization expires <u>one year</u> from the date of signature, **<u>OR</u>** on this date/event:______________________________

I understand that treatment does not depend on me signing this Authorization.

I understand that my child's/ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse.

I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else.

I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Nursing Supervisor, in writing, at the Youngstown Board of Education, 474 Bennington Ave, Youngstown, OH 44505.

______________________ ______________________ ______________
Signature of Patient or Parent/Guardian **Printed Name** **Date**

My relationship to the patient is:

☐ Parent ☐ Legal Guardian* ☐ Self ☐ Other______________________ ***Attach legal papers to show authority to sign.**

______________________ ______________________ ______________
Signature of Witness **Printed Name** **Date**