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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT: Please Print Name _____

Date of Birth _____ Social Security # _____

AUTHORIZATION:

From: _____ To: _____

_____ _____

_____ _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. This authorization will expire 1 year from the date signed.

RECORDS REQUESTED:

_____ COMPLETE CHART
_____ SHOT RECORD
_____ RADIOLOGICAL REPORTS
_____ LABS
_____ HISTORY OR PHYSICAL
_____ OTHER _____

** For records that have more than 25 pages, please mail to 388 Damascus Road, Marysville, OH 43040**

REASON FOR TRANSFER:

I understand that this medical release is to include my requested information being release to the above stated person or entity. This could include information relating to sexually transmitted disease, acquired immunodeficiency virus (HIV), mental/behavioral health services or treatment for drug/alcohol abuse. I understand that signing this authorization is authorizing the release of this information unless specified otherwise.

X _____ _____

Signature — Date
Signature of Parent/Guardian if minor child — Relationship to Patient
Signature of Legal Representative

10-2016