

**UNION HOSPITAL
AUTHORIZATION FOR RELEASE OF INFORMATION**

TO: Union Hospital
659 Boulevard
Dover, Ohio, 44622
Phone: 330-343-3311 ext. 2326

Patient's Name: _____
Date of Birth: _____
Date of Treatment: _____
Soc. Sec. Number: _____

1. I hereby authorize and give my consent to permit:

to examine or receive a copy of records indicated below including diagnosis, HIV testing, care and treatment of AIDS related condition, drug/alcohol abuse and/or psychiatric/mental conditions:

- | | |
|---|---|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> CARDIOPULMONARY REPORTS |
| <input type="checkbox"/> HISTORY AND PHYSICAL | <input type="checkbox"/> PHYSICIAN'S ORDERS/PROGRESS NOTES |
| <input type="checkbox"/> OPERATIVE REPORTS | <input type="checkbox"/> CONSULTATION REPORTS |
| <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> COMPLETE MEDICAL RECORD (do not check this unless entire record is required) |
| <input type="checkbox"/> X-RAY FILM | |
| <input type="checkbox"/> LABORATORY REPORTS | |

2. The above information is released for the following purpose and that purpose only. Any other use is forbidden:

_____ Insurance or other third party reimbursement
_____ Continuity of medical care
_____ Pending legal action
_____ Other (specify) _____

3. A copy of this authorization made by duplicating process shall be valid for all purposes as this original signed by me. I understand that the release form must be dated not more than sixty (60) days before the date on which it is submitted.

4. I was informed of the State of Ohio record fees _____ Initials.

BY SIGNING BELOW I CERTIFY THERE IS NO COURT ORDER IN EFFECT WHICH LIMITS OR PROHIBITS MY ACCESS TO THESE RECORDS.

(Signature) (Date)

Relationship: Self Spouse Guardian Other: _____

A legal document naming guardian or executor of estate must accompany authorization where applicable (proof of legal executor of estate of those patients expired, or legal proof of guardianship).

PLEASE ADDRESS YOUR CORRESPONDENCE TO: "HEALTH INFORMATION MANAGEMENT"

**Please be advised:
The Medical Record is a combination of the printed electronic format and the handwritten forms.**