Southwest General Partnering with University Hospitals

Southwest General Medical Group, Inc.

Patient Label

Date Authorization Received: _____

Authorization to Release Medical Information

Instructions: If any section of this form is incomplete, this form may be invalid. Fees may apply to certain requests.

1. *Patient Information:*	
Name: (First, MI, Last)	Phone: Date Of Birth:
Current Address: City: State: Zip:	Email: ***Medical Record or FIN# (Internal Use)***

2. *Medical Information FROM (the "Provider")*	**3. *Release Information TO (the "Recipient")***
☐ Southwest General Health Center / Hospital (SGHC) ☐ Southwest General Medical Group, Inc. (provide details below) ☐ Other (provide details below)	Name: ☐ (SGHC)
Provider Name:	Address: City: State: Zip:
Facility Name or Location: Phone:	Phone: Fax:

Delivery Method

Mail: ☐ Paper OR ☐ CD ☐ Pick Up (M-F 8:30am-4pm, excludes holidays)

☐ Secure email *(recipient email required):*_____ ☐ Fax (provide fax# in Section 3)

NOTE: Records ineligible for secure email will be mailed.

4. Release the Following Information *(please check all appropriate boxes below):*

***Information Authorized for Release for Date(s) of Service* FROM: _____ TO: _____**

☐ Emer. Dept. Report(s)	☐ Lab Report(s)	☐ Physical/Occupational Therapy	☐ Immunizations
☐ Discharge Summary	☐ Radiology Report(s)	☐ Radiology Images (CD format – only pick up or mail available)	
☐ History & Physical	☐ EKG(s)	☐ HealtheLife *(secure online access to portions of the medical record)*	
☐ Operative Report(s)	☐ Pathology Report(s)	☐ Other (specify):	

Reason for request: ☐ Continuity of Care ☐ Personal ☐ Other *(specify):* _____

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

I, the undersigned, authorize the Provider listed in Section 2 to release medical information as indicated/described in Section 4 above. This authorization may be revoked in writing to the Medical Records Department (address below). I understand revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is released pursuant to this authorization, it may be re-disclosed by the Recipient and the information may not be protected by federal privacy regulations. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical or psychiatric condition, HIV test results, an AIDS diagnosis, and or alcohol/drug abuse. I expressly consent to the release of information as designated above.

X_____ _____

Signature of Patient or Personal Representative Date

X_____

Relationship, if not patient

ATTENTION RECIPIENT: If the records released include information of HIV-related diagnosis or test results, or any diagnosis or treatment from a substance abuse treatment program, the following statement applies: *This information has been disclosed to you from confidential records protected from disclosure by State law or Federal Confidentiality Rules. These regulations prohibit you from making any further disclosure of this information without the specific written and informed consent of the individual to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (Ohio Revised Code 3701.243) & (42 C.F.R. Part 2) respectfully.*

If you have any questions, please call (440) 816-8480.

Southwest General Health Center, Medical Records Department • 18697 Bagley Road • Middleburg Heights, Ohio 44130.