Southwest General
Partnering with University Hospitals

Patient Label

Authorization for the Release of Medical Information

The following information is required to process this release.

I, _____, born on ____/____/____
Last Name First Name Middle Initial Month Day Year

Address: _____

Phone Number: _____

hereby authorize ☐ Southwest General Health Center ☐ Other: *(the"Provider")* _____

to release and furnish to ☐ Southwest General Health Center **or**

☐ Other: *(Name and address)* _____ *(the "Recipient")*

the following information contained in the medical record regarding my hospitalization, care and/or treatment on the following dates:_____ to _____ as an ☐ ER patient ☐ Inpatient ☐ Outpatient *(specify)*:_____

Information Authorized For Release *(Please check all appropriate boxes)*

☐	E. R. Report(s)	☐	Laboratory Report(s)	☐	Operative Report(s)	☐	Radiology Report(s)
☐	Discharge Summary	☐	Pathology Report(s)	☐	EKG(s)	☐	Radiology Images (CD format)
☐	History & Physical	☐	Physical Therapy Report	☐	EMG Report(s)		**must be picked up in Radiology**
☐	MyHealth Invitation		Occupational Reports				
☐	Other *(specify)*:						
☐	Electronic Discharge Summary (CD format)			☐	Electronic Summary of Care Document (CD format)		

Method of Release: (NOTE: Copies released directly to the patient may require a copy fee (ORC 3701.742)

☐ Mail ☐ Pick up *(M-F 8:30am-4pm only, excluding holidays)* ☐ CD Pick up *(M-F 8:30am-4pm only, excluding holidays)*

☐ **Radiology Images (CD Format) pick up in Radiology Department (x2702)**

Reason for request: ☐ Patient Request ☐ Other *(specify)*: _____

This authorization is valid for ☐ 90 days or until _____ (not to exceed 90 days). This authorization may be revoked in writing to the Provider (for Southwest General Health Center, make your request to Health information Services/Medical Records). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is disclosed 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 I am not obligated to sign this authorization and that the Provider may not condition the provision of treatment, payment, enrollment or eligibility for benefits to me on the signing of this authorization.*****

Purpose of Disclosure:

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 Person Authorized to Consent Date Time

X _____ X _____ _____
Relationship, if not Patient Witness Date

If the records released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies to the Recipient: *This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical records 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.*

If the records released include information of HIV-related diagnosis or test results, the following statement applies to the Recipient: *This information has been disclosed to you from confidential records protected from disclosure by State law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by State law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.*

Medical Record # _____ **Date Completed Authorization Received:** _____

** If the authorization is for research purposes or if the services are being provided solely to be released to another (such as Workers Compensation evaluation), do not use this form. Use a specific form prepared for that purpose.*

If you have any questions, please call Southwest General Health Center Medical Record Department at (440) 816-8480.
Our address is 18697 Bagley Road • Middleburg Heights, Ohio 44130.

16400X 1113