

**Family Practice Center, Inc.**  
**365 S Crownhill Rd**  
**Orrville, OH 44667**  
**(330) 682-3075**



## AUTHORIZATION TO RELEASE & DISCLOSE HEALTH INFORMATION

\*\*\*A copying charge will be billed and must be paid before records are released. Please call Family Practice Center, Inc. records department @ 330-682-3075 for these details.\*\*\*

Patient Name: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_\_ Health Record Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

1. I authorize the use or disclosure of the above-named individual's health information as described below. I understand that this authorization extends to release of the health information via U.S. Mail, overnight mail, telephone, facsimile machine (fax), or internet access.

2. The following individual or organization is authorized to make the disclosure: **FAMILY PRACTICE CENTER, INC., 365 S CROWNHILL RD, ORRVILLE, OH 44667, phone (330) 682-3075.**

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> problem list        | <input type="checkbox"/> medication list                | <input type="checkbox"/> allergy list                  |
| <input type="checkbox"/> immunization record | <input type="checkbox"/> most recent history & physical | <input type="checkbox"/> most recent discharge summary |
| <input type="checkbox"/> laboratory results  | <input type="checkbox"/> x-ray and imaging reports      | <input type="checkbox"/> consultation reports          |
| <input type="checkbox"/> entire records      |   |  |

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

From (doctor or facility name) \_\_\_\_\_

Other info \_\_\_\_\_

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organizations:

Address: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in sixty (60) days.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for and unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Administrator at Family Practice Center, Inc.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness