981 Wooster Road
Millersburg, OH 44654
(330) 674-1015

patient label

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
First Middle Last

Social Security Number: _____ Date of Birth:_____

I, the undersigned, hereby authorize _____
to provide Pomerene Hospital, 981 Wooster Road, Millersburg, Ohio 44654 with the following information:

- ❑ Pertinent Summary (includes all *items below if contained in the record)

❑ Admission Form ❑ *Face Sheet	❑ *Pathology Report	❑ Respiratory Reports
❑ *Discharge Summary	❑ Physician Progress Notes	❑ Medications/Treatments Report
❑ *Emergency Room Report	❑ Lab Report	❑ Nurses Notes
❑ *History & Physical	❑ Radiology Report	❑ Entire Record
❑ *Consultation Report	❑ Radiology Film	❑ HIV and/or AIDS test results
❑ *Operative Report	❑ EKG Report	❑ Other _____
❑ *Special Procedure	❑ Stress/Echo	_____

From the following date of service/treatment: _____

Purpose of Disclosure: _____

❑ I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human immunodeficiency Virus (HIV) test results, Acquire Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse.

❑ I have legal authority to obtain health information on behalf of my minor child.

Parent / Guardian Signature: _____ Date: _____ Time: _____

THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID FOR **12 MONTHS** FROM THE DATE OF SIGNATURE, UNLESS REVOKED BY WRITTEN NOTICE TO THE PROVIDING INSTITUTION, PROVIDING SAID NOTICE IS RECEIVED PRIOR TO RELEASE OF INFORMATION.

VERIFICATION OF IDENTITY (See attached page):

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____

Signature & Date of Receipt of Records: _____