Release of Medical Information

Patient Name: ___________________________________ **Birth date:** ________________________

Patient Name: ___________________________________ **Birth date:** ________________________

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By signing this authorization form, you are agreeing to the disclosure of your health information. This office will not condition providing treatment to you on your execution of this authorization form. You have the right to revoke this authorization by requesting to and completing the revocation section of the form below if we have not acted in reliance on this authorization.

I hereby authorize ____ to make the use or disclosure of my health information as set forth below.

Information to be disclosed*:

- ❑ All Medical Records
- ❑ Immunization Records Only
- ❑ Other (Please Specify): ____

Records to be forwarded to: Children's Intensive Caring
4405 N. Holland Sylvania Rd. #102
Toledo, OH 43623

Purpose for Disclosure:

____

____

This authorization expires after 6 months from the date of signature.

Please be aware that any information that is disclosed to a third party pursuant to this authorization may be subject to disclosure and no longer protected by our policies and applicable law. The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/or substance abuse, and mental illness.

___________________________ ____

Date Signed Signature of Patient and/or Guardian

*****REVOCATION*****

(To be completed by patient if patient subsequently wishes to revoke authorization)

I hereby revoke this authorization.

___________________________ ____

Date Signed Signature of Patient and/or Guardian

*Ohio law states that you may not be charged more than the following record copying:

- First 10 pages: $2.50/page
- Pages 11-50: 50 cents/page
- Pages > 50: 20 centers/page
- Cost of postage is additional