canyon medical • center
Internal Medicine and Pediatrics
"Care" for the whole family
(614) 864-6010
Toll Free: 866-877-1757
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5969 E. Broad Street . Suite 200 . Columbus, Ohio . 43213-1546

AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____PHONE: _____

CITY:_____ STATE:_____ ZIP:_____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION AS IT RELATES TO MY CARE TO AND FROM THE PARTIES LISTED BELOW:

TO DR.: _____ FROM DR.: _____

@_____ @_____

_____ _____

_____ _____

THE PURPOSE OF RELEASE (CHECK APPLICABLE PURPOSE)

_____TO PROVIDE CONTINUITY OF CARE _____WORKER'S COMPENSATION

_____INSURANCE OR OTHER THIRD PARTY _____LEGAL

_____PERSONAL _____OTHER:_____

INFORMATION TO BE RELEASED (CHECK ALL APPLICABLE)

_____ALL INFORMATION INCLUDING HIV/AIDS, MENTAL ILLNESS AND DRUG/ALCOHOL ABUSE.

_____ALL INFORMATION EXCLUDING HIV/AIDS, MENTAL ILLNESS AND DRUG/ALCOHOL ABUSE.

_____IMMUNIZATION RECORDS _____LAB REPORTS

_____XRAY/CARDIOLOGY REPORTS _____OTHER

RECORDS FROM THE TIME PERIOD ____/____/____ THROUGH ____/____/____

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID FOR ONE YEAR. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANYTIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. I UNDERSTAND THAT THERE WILL BE A PRE-PAYMENT FEE FOR THE TRANSFERRING OF RECORDS.

PATIENT'S SIGNATURE: _____ DATE: _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____ DATE: _____

INTIALS OF STAFF: _____