333 Conover Drive,
Suites B & D
Franklin, OH 45005
513.318.1188
513.318.1189 (fax)

Authorization for Release of Medical Information

I hereby grant permission for the release of the following medical information relating to my care from and to the parties named below.

From: _____ To: Centerpoint Health

_____ 333 Conover Dr. Suites B & D

_____ Franklin, Ohio 45005

The purpose of this request is for:

□ Continuity of Care □ Legal matter □ Other (specify) _____

□ Insurance Claim □ At the request of the individual

_____ _____
Patient's Name Date of Birth

_____ _____
Name at time of treatment Social Security Number

_____ _____
Patient's Address Telephone Number

Date (s) of treatment: (MM/YY) _____

This information may include treatment of rehabilitation for drug, and/or alcohol abuse, psychiatric treatment, HIV, Antibody Test (test for AIDS virus), and related conditions, if they did occur. I specify that this release is to include:

□ Face Sheet □ Laboratory report □ Mental Health treatment
□ Discharge Summary □ Radiological reports □ Other specified here:
□ History & Physical □ Operative reports _____
□ Consultation □ Pathology Reports _____
□ Emergency Room Treatment _____
□ Drug/Alcohol abuse treatment

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be withdrawn at any time in writing, and that this authorization will expire 90 days after date of signature unless I specify and earlier expiration date.

_____ _____
Date Signature of patient/patient's representative