333 Conover Dr
Franklin, Ohio 45005
513-318-1188
513-318-1189 (fax)

Authorization for Release of Records

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

From: Centerpoint Health
333 Conover Dr.
Franklin, Ohio 45005

To: _____
_____
_____

_____ Name

_____ Date of Birth

_____ Name at time of treatment

_____ Social Security Number

_____ Address

_____ Telephone Number

Date(s) of treatment: (mm/yy) _____

This information may include treatment of rehabilitation for drug/alcohol abuse, psychiatric treatment, HIV/Antibody Test (test for AIDS virus), and/or related conditions.
I specify that this release is to include (circle what's requested):

Face sheet	Consultations	Operative reports
After Visit Summary	Radiological Reports	History and Physical
Consultations	Laboratory Report	Emergency Reports

Other: _____

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 I understand that this authorization may be withdrawn at any time in writing and this authorization will expire 90 days after date of signature unless I specify an earlier expiration date.

_____ Date

_____ Signature of patient/patient's representative