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: Dr./Office Name:
Street Address:
City, State, Zip:
Phone:
Fax:

To: Centerpoint Health
333 Conover Dr, Suites B and D
Franklin, OH 45005
Phone: 513-318-1188 Fax: 513-318-1189

_____ _____
Printed Legal Name of Patient (at time of treatment) *Patient's Date of Birth*

_____
Address of Patient *City, State, Zip Code*

_____ _____ _____
Patient's Social Security Number *Phone Number of Patient* *Dates of Treatment (mm/yy)*

Purpose of Request:

- ☐ Continuity of Care
- ☐ Legal Matter
- ☐ Insurance Claim
- ☐ Patient Request
- ☐ Other: _____

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

- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ Radiological Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ History & Physical Consultation
- ☐ Emergency Room Treatment
- ☐ Drug/Alcohol Abuse Treatment
- ☐ Mental Health Treatment

Other: _____

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 I understand this authorization may be withdrawn at any time in writing, and this authorization expires 90 days after date of signature unless I specify an earlier expiration date.

_____ _____
Signature of Patient or Responsible Party *Date*