FIRELANDS Regional Health System

Health Information Management Department

Authorization to Release Copies of a Medical Record

I HEREBY AUTHORIZE RECORDS FROM:

☐ **Firelands Regional Medical Center**
1111 Hayes Ave., Sandusky, OH 44870
Phone: 419-557-7435
Fax: 419-557-5738
(Hospital Records Only)

☐ **North Coast Professional Group, LLC, dba Firelands Physician Group**
1111 Hayes Ave., Sandusky, OH 44870
Phone: 419-557-5552
Fax: 419-557-7832
(Physician Office Records Only)

Patient Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ Medical Record Number: _____

City/State/Zip: _____ Phone: _____

Email Address: _____ Fax: _____

I hereby authorize records FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

To be released TO:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax:_____

Purpose of release/disclosure: ☐ Continuity of Care ☐ Request of Patient ☐ Other (Please Specify) _____

_____Treatment Date (s): _____

Information to be released: (check all that apply)

☐ Discharge Summary ☐ Emergency Department Report ☐ Radiology / Ultrasound Reports ☐ Operative Reports

☐ History & Physical ☐ Physician Office Notes ☐ Laboratory Reports ☐ Psychiatric Health Record

Information to be: ☐ Emailed ☐ Mailed ☐ Picked-Up ☐ CD ☐ Paper Copy

I hereby authorize Firelands Regional Health System, its Agents and its Employees to release Protected Health Information about me/my child to the recipient, which may include test results, diagnosis, treatment or other information about HIV or other communicable disease. If any, alcohol and drug information protected by Federal Regulation (42CFR Part 2), if any, and mental health information if any.

1. I am the patient, or the legally authorized representative of the patient, listed above. I request Firelands Regional Health System to release my protected health information (or the patient information listed above) to:
2. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taken in reliance of this authorization. Unless otherwise revoked this authorization is valid for 180 days.
3. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
4. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibit by law.
5. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on my failure to sign this authorization form.
6. I understand there may be charges for the copying and release of information and I accept financial responsibility.
7. A photocopy is as valid as the original.

Patient or Person Authorized to Consent: _____ Date: _____

Signature _____ Relationship to Patient _____