



Authorization to Release Copies of a Medical Record

HIPAA Privacy/Release of Information Department

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: 419-557-7872
(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:

To be released TO:

Name:
Address:
City, State, Zip:
Phone: Fax:

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 Other:

Information to be: Emailed Mailed Picked-Up CD Paper Copy Patient Portal Upload (Hospital Records only)

I, the undersigned, authorize Firelands Regional Health System and its agents/employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immunodeficiency Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA/Release of Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization. I understand there may be charges for the copying and release of Information and I accept financial responsibility.

Patient or Person Authorized to Consent: Date:

Signature Relationship to Patient