Memorial INTERNAL MEDICINE

Authorization for Release of Medical Information

PATIENT: PRINTED PATIENT'S NAME: _____
DATE OF BIRTH: _____
DATE OF TREATMENT: _____ SOC. SEC. #_____

AUTHORIZATION: (Previous physician/medical provider information)
I hereby authorize _____ to release/disclose the above named individual's health information.

The information to be disclosed is as listed, please be specific.

_____ Assessment/History and Physical – Dates of Service: _____

_____ Discharge Summary – Date(s) of Service: _____

_____ Lab Tests – Date(s) of Service: _____

_____ Radiology Reports – Date(s) of Service: _____

_____ Entire Record – Date(s) of Service: _____

_____ Photographs, videotapes, digital, or other images: _____

_____ Other, please specify needed information and date(s) of service if known: _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above.

The information is to be released to:

Name: Memorial Internal Medicine, LLC

Address: 660 London Avenue, Suite A, Marysville, Ohio 43040

_____ (initials) Patient requests records to be faxed to another facility or physician's office. Patient is aware of confidentiality risks involved and releases Memorial Internal Medicine, LLC of responsibility of this fax.

Fax Number: 937-578-2821

(Turn over and Complete Back Page)

PURPOSE:
The purpose for the release of this information is:

_____ Insurance or other Third Party Reimbursement
_____ Continuity of medical care

_____ Pending legal action
_____ At the request of the patient
_____ Other: (Specify) _____

RESTRICTIONS:
According to the Federal and State regulations, if the medical information requested relates to AIDS/HIV treatment of treatment in a federally-recognized chemical dependency unit, then the information will be accompanied with a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that although the Memorial Internal Medicine, LLC has a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information id disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Memorial Internal Medicine, LLC will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Memorial Internal Medicine, LLC of any liability which may arise as a result of any subsequent disclosure of my health information by the recipient.

Understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

DURATION:
This authorization will remain valid for 60 days from today's date or at an earlier date, at my election. 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 health information management department. I understand that the revocation will not apply to information that has already been released in response to the 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.

SIGNATURE:

PATIENT SIGNATURE:_____

PERSONAL/LEGAL REPRESENTATIVE SIGNATURE: _____

IF SIGNED BY PERSONAL/LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: _____

TODAY'S DATE: _____

PROVIDE A COPY OF THIS SIGNED FORM TO THE PATIENT OR PERSONAL/LEGAL REPRESENTATIVE