OhioHealth Primary Care & Pediatric Physicians
Formerly Delaware Primary Care
801 OhioHealth Blvd, Suite 260, Delaware, OH 43015
Phone: 740 615-0500 Fax: 740 615-0501

Authorization for the Release of Medical Information

Patient Name: _____ DOB:_____

Address: _____

City, State & Zip Code: _____

Name used when treatment occurred: _____

I hereby grant permission for the release of medical information relating to my care from and to the parties named here:

From ***(include name, address, phone & fax number)***	**To**
_____	_____
_____	_____
_____	_____

The purpose of the release of information is:
____Changing Doctor/Moving from Area
____ Insurance or other Third-Party Reimbursement
____ Pending Legal Action ( ) MVA ( ) SS Claim; ( ) Industrial Claim

This authorization specifically pertains to information related to my treatment that occurred on or between _____.
date(s)

I understand that this medical information will contain copies of physician office records for designated date(s) listed above, which pertain to my evaluation and treatment. Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, it is not a condition of treatment. The protected health information released may include information concerning testing, diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), SEXUALLY TRANSMITTED DISEASE, PSYCHIATRIC AND OR DRUG/ALCOHOL TREATMENT that may be in my medical record.

This authorization may be revoked at any time in writing to the office Manager of this practice. The revocation will not apply to information that has already been released. This authorization for the release of medical information is valid for 60 days from the date signed below. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by this rule.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (if other than the patient) Witness (if applicable)