Cleveland Clinic

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM MAIN CAMPUS OF THE CLEVELAND CLINIC

Health Data Services, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

216/444-2640
800/223-2273 ext. 42640
Fax: 216/445-7589

Patient: _____ SS#: _____-_____-_____

Clinic #: _____ Date of Birth: _____ /_____ /_____

Telephone #: _____ Current Address: _____

City: _____ State: _____ Zip: _____

Check mark all other facilities/entities records are to be released from:

□ Cleveland Clinic Homecare Services □ Cleveland Clinic Taussig Radiation Oncology □ Cleveland Clinic Subacute Unit

□ Other (Please list all additional Cleveland Clinic Family Health Center locations and other Cleveland Clinic physician offices below.)

□ _____ □ _____ □ _____
□ _____ □ _____ □ _____
□ _____ □ _____ □ _____

I hereby authorize the Cleveland Clinic to release the health information indicated below that is contained in my patient records to the Recipient named below. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

Name of Recipient: _____ Telephone: _____
(please print)

Street: _____

City: _____ State: _____ ZIP:_____

Reason for Disclosure: _____
(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment: _____

□ Office Visits
□ Emergency Department Reports
□ Discharge Summary
□ Operative Reports
□ History & Physical
□ Cardiac Reports
□ Laboratory Reports
□ Radiology Reports
□ Physical/Occupational Therapy Reports
□ Other _____
□ Other _____
□ Other _____

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.** I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

_____ / _____ _____ /_____ /_____
*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____
Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*

*** For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*