ADVANCED HEALTH
Wellness Center

MEDICAL RECORD
RELEASE OF INFORMATION AUTHORIZATION

WHO

Patient Name: _____ Date of Birth: ____/____/____ SSN #: (last 4) _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (_____) _____-_____

FROM

I hereby authorize records FROM:

Advanced Health and Wellness Center, LLC

201 Great Oaks Trail, Wadsworth, OH 44281 Phone: 330-336-9500 Fax: 330-336-3377

TO

To be released TO:

Physician Name/Facility/Self (Self for personal copies): _____

Address: _____

City, State, Zip: _____ Phone:_____

HOW

Delivery options:

☐ E-mail: _____ I understand email is non-secure and the risks were explained to me. I request records to be emailed. _____ Initials

☐ Fax: _____ ☐ Paper

WHAT

Date of Service: From ___/___/____ To ___/___/____

☐Physician Office Notes ☐Radiology Reports ☐CD (Radiology Images only) ☐Lab/Path Reports

☐ Other specified: _____ ☐ All

WHY

Purpose of Disclosure: (Please select one)

☐Referral ☐Transfer of Care ☐Insurance ☐Workman's Comp ☐Legal Investigation

☐ Disability Determination/Claim ☐ Personal ☐ Other:_____

SIGNATURE

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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 Medical Records 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.

*This release expires one year from date signed, unless I specify an expiration date: ___/___/____.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature: _____ **Print Name:** _____ **Date:** _____

If Signed by Representative, List Relationship to the Patient: _____