

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. _____ ☐ Fax: _____ ☐ Paper _____ Initials
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: _____