

**AUTHORIZATION FOR
RELEASE OF MEDICAL
INFORMATION**



Fairview Hospital
Lakewood Hospital
Lutheran Hospital

Cleveland Clinic hospitals

I give permission to _____ Hospital to

Release To Receive From

Name of person/Doctor/Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: H () _____ W () _____ Fax: () _____

*****Reason for Disclosure: (Must be completed prior to processing)**

Continuity of Care/Follow Up Personal Use Legal Insurance

Other (specify): _____

*****INFORMATION TO BE RELEASED: (Must be completed prior to processing)**

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Pertinent Summary Information | <input type="checkbox"/> History & Physical | <input type="checkbox"/> EKG |
| <input type="checkbox"/> ED Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Physical/Occupational
Therapy Reports | <input type="checkbox"/> Consult Reports |

Other (specify): _____

***Dates of Treatment: _____

Patient Name: _____ Date of Birth: _____ SSN: _____ MRN: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: H () _____ W () _____ Fax: () _____

I hereby authorize Cleveland Clinic Health System Hospital(s) to release or receive the health care information indicated above that is contained in my patient record. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis. This authorization may be revoked at any time by putting the revocation in writing and presenting it to Health Information Services. Any revocation will not apply to information that has already been released in response to this authorization. This authorization and consent will expire one year from the date of authorization written below. Any further disclosure requires the specific written consent of the person to whom it pertains or his/her legal representative; reliance on Cleveland Clinic Health System Hospital(s)' authorization for release of relevant information is not sufficient for purposes of redisclosure.

***This authorization for release of information is not valid, according to privacy rule, if the asterisked areas on this authorization form have not been completed.

***Signature of Patient / Legal Guardian / Administrator
Executor or Next of Kin (Circle one)

Printed Name

***Date Signed

If patient unable to sign state reason why

Witness

Identification Verified:
 Yes No