Pomerene HOSPITAL
981 Wooster Road
Millersburg, OH 44654
(330) 674-1015

patient label

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
First Middle Last

Social Security Number: _____ Date of Birth:_____

I, the undersigned, hereby authorize Pomerene Hospital to provide

_____ , _____
(name of person or organization) (address of person or organization)

_____with the following information:

- ❑ Pertinent Summary (includes all *items below if contained in the record)
- ❑ Admission Form ❑ *Face Sheet
- ❑ *Discharge Summary
- ❑ *Emergency Room Report
- ❑ *History & Physical
- ❑ *Consultation Report
- ❑ *Operative Report
- ❑ *Special Procedure
- ❑ *Pathology Report
- ❑ Physician Progress Notes
- ❑ Lab Report
- ❑ Radiology Report
- ❑ Radiology Film
- ❑ EKG Report
- ❑ Stress/Echo
- ❑ Respiratory Reports
- ❑ Medications/Treatments Report
- ❑ Nurses Notes
- ❑ Entire Record
- ❑ HIV and/or AIDS test results
- ❑ Other _____
  _____

From the following date of service/treatment: _____

Purpose of Disclosure: _____

❑ I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human immunodeficiency Virus (HIV) test results, Acquire Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse.

❑ I have legal authority to obtain health information on behalf of my minor child.

Parent / Guardian Signature: _____ Date: _____ Time: _____

THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS VALID FOR **12 MONTHS** FROM THE DATE OF SIGNATURE, UNLESS REVOKED BY WRITTEN NOTICE TO THE PROVIDING INSTITUTION, PROVIDING SAID NOTICE IS RECEIVED PRIOR TO RELEASE OF INFORMATION.

VERIFICATION OF IDENTITY (See attached page):

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____

Signature & Date of Receipt of Records: _____