

Authorization for Release of Health Information

PATIENT INFORMATION (Please Print)				
First Name:	Middle Initial:	Last Name:	Last Name:	
Name at Time of Treatment (if different than above):	Date of Birth (MM/DD/YYY	Phone:	none:	
Street Address:	City:	State:	Zip:	
WHAT RECORDS DO YOU WANT? (Check appropriate	e boxes below)	,		
Records from: \Box CHMC Hospital \Box CHMG - Provide	r/Practice Name:			
Date(s) of Service:/ through _ □ Complete Records □ Emergency Room □ Discharge Summary □ Lab/Pathology Re □ Other (Immunization Records, Medication Lists, Beha	n Records ☐ History & F esults ☐ Imaging Re	esults Patient Acc	ct (Billing) Records	
WHAT IS THE PURPOSE FOR THIS RELEASE OF INF	ORMATION?			
☐ Continuation of Care☐ Disability Determ☐ Applying for Insurance☐ Other: Please specifies	• •	☐ Legal Purposes ☐ Payment of Insurance Claim		
		Recipient Phone: Recipient Fax:		
I UNDERSTAND:				
This authorization will expire twelve (12) months from	•			
 Released information may include records related to This authorization may be revoked, in writing only receipt of revocation. 		•		
Once information covered by this authorization hunderstand the information may no longer be protect.			•	
I agree to pay any applicable fees for the processing	g of this request.			
PLEASE SIGN YOUR NAME BELOW:				
Signature of Patient or Personal Representative Relationship t		Patient (Please Print)		
Witness Signature	Date / Time	Date / Time		
Patient Medical Record No.:	Patient Accou	Patient Account No.:		

