AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT NAME	LAST	FIRST	MIDDLE
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
THE UNDERSIGNED HEREBY AUTHORIZE:			

☐ SUMMA AKRON CITY/ST.THOMAS HOSPITALS ☐ SUMMA WESTERN RESERVE HOSPITAL

☐ CUYAHOGA FALLS GENERAL HOSPITAL ☐ OTHER:______________________________

PROVIDE: *(Name of Person or Organization)*

NAME

STREET	CITY	STATE	ZIP CODE

FOR THE FOLLOWING DATES OF SERVICE / TREATMENT:______________________________

PURPOSE OF DISCLOSURE

☐ Billing
☐ Personal
☐ Legal
☐ Health Care
☐ Research
☐ Fund Raising
☐ Marketing
☐ Other ______________________________

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

I understand that I am not required to sign this authorization form and that the health care provider named above will not condition the provision of treatment or payment to me on the signing of this authorization, except that the health care provider named above may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. The health care provider named above may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal policy regulations.

I understand that I may revoke this authorization at any time by notifying the health care provider named above in writing, except to the extent that 1) action has been taken in reliance on this authorization; or 2) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

☐ Pertinent Summary (includes all *items below if contained in the record)		
☐ Admission Form	☐ *Special Procedure	☐ Respiratory Report
☐ *Facesheet	☐ *Pathology report	☐ Medications / treatment report
☐ *Discharge Summary	☐ *Cardiac Cath Report	☐ Nurses Notes
☐ *Emergency Room Report	☐ *Lab Reports	☐ Entire Record
☐ *History & Physical	☐ *Radiology Report	☐ Other ____________
☐ *Consultation Record	☐ *EKG Report	
☐ *Operative Report	☐ *EEG Report	

______________________________ ______________
SIGNATURE OF PATIENT DATE

____
PRINTED NAME OF LEGAL REPRESENTATIVE

______________________________ ______________
SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE DATE

☐ Guardian ☐ POA
☐ Executor ☐ Person Responsible for Estate

90130200 (2/11)