AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

900 Club Drive
Westerville, OH 43081
Phone: 614-899-2838
Fax: 614-899-2872

Patient Name: _____ **Date of Birth:** _____

Select one of the following: □ Oakstone Health Center to provide copies
□ Oakstone Health Center to obtain copies from
_____

A. Reason for Request: □ Continued care □ Insurance □ Attorney □ Personal Use □ Other_____

B. Information Needed _____

C. Method of Delivery □ Fax □ Pick up paper copy at Oakstone Health Center

Doctor/Organization: _____
Address: _____
Phone: _____
Fax: _____

I understand that the medical information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, and/or a communicable disease including HIV/AIDS. I understand that I may revoke (cancel) this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I revoke this authorization, I must do so in writing to Oakstone Health Center. Unless otherwise revoked, this authorization will automatically expire 90 days after the date signed. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Patient Signature: _____ **Date Signed:** _____

When someone other than the patient signs, the following must be completed:

I, _____ (print your name), hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization, and agree that Oakstone Health Center may disclose the medical information of such individual for the purpose set forth.

Signature of Representative: _____ **Date Signed:** _____

Relationship to Patient: □ Parent □Guardian □Executor of State □Power of Attorney □Other _____

This Section to be completed by Oakstone Health Staff

Date Information Released: _____ Intials of who completed release: