AUTHORIZATION TO RELEASE COPIES OF A MEDICAL RECORD

Family Health Services
1912 Hayes Ave
Sandusky, OH 44870
Phone: 419-502-2800
Fax: 419-502-2821

Family Health Services
620 E. Water St
Sandusky, OH 44870
Phone: 419-502-2800
Fax: 419-502-2821

Family Health Services
265 Benedict Ave
Norwalk, OH 44857
Phone: 419-502-2800
Fax: 419-502-2821

Patient Name: _____ DOB: _____

I hereby authorize records FROM:	**To be released TO:**
Facility: _____	Facility: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

For treatment dates between: _____ ☐ Any/All treatment dates at facility

Types of information to be disclosed:

☐ Admission Summary ☐ Diagnostic Assessment ☐ Progress Report ☐ IEP/504 Plan ☐ Discharge Summary
☐ Medication History ☐ Drug Treatment ☐ Lab Reports ☐ Psychological Testing
☐ Other: _____

I hereby authorize Family Health Services, its agents and its employees to release Protected Health Information about me/my child to the recipient, which may include test results, diagnosis, treatment, or other information about HIV or other communicable disease. If any, alcohol and drug information and mental health information are protected by Federal Regulation (42CFR Part 2).

1. I am the patient, or the legally authorized representative of the patient listed above.
2. This authorization may be revoked in writing by sending it to the address at the top of this form at any time, except to the extent that action has been taken in reliance of this authorization. Unless otherwise revoked this authorization is valid for 180 days.
3. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
4. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Family Health Services policies and applicable law unless re-discloser is specifically prohibited by law.
5. I understand there may be charges for the copying and release of information and I accept financial responsibility.
6. A photocopy is as valid as the original.

_____ _____
Signature of Patient (Parent or Guardian if patient is minor) Date

_____
Relationship, if not patient

Updated: 2/22/2024