Cleveland Clinic

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name:_____ SS#:_____

CC#:_____ Date of Birth: _____ / _____ / _____

Telephone #:_____ Address:_____

City:_____ State:_____ Zip:_____

Name of Healthcare Facility from which Records are Requested:

_____

Address: _____

Street: _____

City: _____ State:_____ Zip:_____

Dates of Treatment Requested: _____

Reason for Disclosure: _____

	MAIL INFORMATION TO:	**OR**	**MAIL INFORMATION TO :**
Release Medical Information to: (please check one box and provide needed information)	☐ Cleveland Clinic c/o _____ Mail Code:_____ 9500 Euclid Avenue Cleveland, OH 44195 Phone: _____ Fax: _____ Department: _____		☐ _____ _____ _____ _____

I hereby authorize Cleveland Clinic to obtain the health information indicated below that is contained in my patient records to the Recipient named above. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization**. **Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.**

	Emergency Department Reports		Pathology Reports
	Discharge Summary		Laboratory Reports
	History & Physical		Radiology Reports
	EKGs		Operative Reports
	Physical/Occupational Therapy Reports		Other (Specify)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.**

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ / _____ _____ / _____ / _____

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____

Relationship if not Patient

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*

***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate certificate is required coupled with the documents naming the administrator or executor of the estate.*