MetroHealth Medical Center
2500 MetroHealth Drive, Cleveland, Ohio 44109-1998

AUTHORIZATION TO **RELEASE** PROTECTED HEALTH INFORMATION **TO** ANOTHER FACILITY

I hereby grant permission for The MetroHealth System to release a copy of my medical records. **I understand that the information released upon authority of this authorization may contain information concerning treatment for a sexually transmitted disease, alcohol, drug abuse, a psychiatric condition, or HIV test results, an AIDS diagnosis, or AIDS-Related condition.** I further understand authorization does not include permission to release outpatient Psychotherapy notes. The release of Psychotherapy notes requires a separate authorization (Psychotherapy notes are separated from the rest of a patient's medical record).

This authorization is valid for a period of 60 days from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance. The revocation must be provided to the MetroHealth Medical Record Department.

SPECIFIC INFORMATION TO BE RELEASED:

_____

_____

_____

_____

FOR THE PURPOSE OF: Legal Review ☐ At the patient's request.

The copy of the medical record is to be released to:

NAME: The Law Office of Christine LaSalvia

STREET: 614 W. Superior Ave., #820

CITY/STATE/ZIP/COUNTY: Cleveland, OH 44113

PATIENT NAME: _____OTHER NAME(S): _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____ SSN: _____-_____-_____

MHS MEDICAL RECORD #: _____ TELEPHONE NUMBER: (_____)_____

PATIENT'S SIGNATURE: _____ DATE: _____/____/_____

My health care (or payment for care) will not be affected by whether or not I sign this authorization. Once my health care information is released, redisclosure of my health care information by the recipient may no longer be protected by law.

Signature of Authorized Representative (Please state relationship)*:

_____(_____)DATE: _____/____/_____

*If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney or Death certificate) **MUST** accompany the authorization when presented. Exception: parent is signing for patient under age 18.

NOTE: An incomplete or improper authorization cannot be honored.

[METROHEALTH STAFF ONLY: Request pro cessed or facilitated by :_____in (Department Name):_____ at (Facility Name):_____
❒ *Faxed on* _____ *(Date)* *OR* ❒ *Mailed on:* _____ *(Date)*

MetroHealth Medical Center
2500 MetroHealth Drive, Cleveland, Ohio 44109-1998

AUTHORIZATION TO **OBTAIN** MEDICAL RECORDS **FROM** ANOTHER FACILITY

I hereby grant permission to:

NAME OF FACILITY/PROVIDER: _____

STREET: _____

CITY/STATE/ZIP/COUNTY:_____

release a copy of my medical records. **I understand that the information released upon authority of this authorization may contain information concerning treatment for a sexually transmitted disease, alcohol, drug abuse, a psychiatric condition, or HIV test results, an AIDS diagnosis, or AIDS-Related condition.** I further understand this authorization does not include permission to release outpatient Psychotherapy notes. The release of Psychotherapy notes requires a separate authorization (Psychotherapy notes are separated from the rest of a patient's medical record).

This authorization is valid for a period of 60 days from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance.

SPECIFIC INFORMATION TO BE RELEASED: _____

_____

FOR THE PURPOSE OF: ❒ Patient Care or ❒ Other: _____

The copy of the medical records is to be released to (mark only ONE box):

☐ ATTN: Dr. _____
Department: _____
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, OH 44109
(216) 778-_____

-or-

☐ Medical Record Department
MetroHealth Medical Center
2500 MetroHealth Drive
Cleveland, OH 44109
(216) 778-4252

-or-

☐ Other MHS Locations (fill in address)
_____
_____
_____

PATIENT NAME: _____ OTHER NAME(S): _____

PATIENT ADDRESS: _____

DATE OF BIRTH: _____ SSN: _____-_____-_____

MHS MEDICAL RECORD #: _____ TELPHONE NUMBER: (_____)_____

PATIENT'S SIGNATURE: _____ DATE: _____/____/_____

OTHER FACILITY'S MEDICAL RECORD NUMBER (if known): _____

If patient is deceased, administrator of patient's estate or nearest relative may sign. If patient is a minor, parent or legal guardian must sign below. Please attach supporting, legal documentation.

Signature of Authorized Representative (Please state relationship):

_____(_____) DATE: _____/____/_____

NOTE: An incomplete or improper authorization cannot be honored.

[METROHEALTH STAFF ONLY: Request processed or facilitated by _____in (Department Name):_____ at (Facility Name):_____
❒ *Faxed on* _____ *(Date)* *OR* ❒ *Mailed on:* _____ *(Date)*