FIRELANDSHEALTH
Firelands Regional Medical Center

* R E L E A S E *

FIRELANDSHEALTH
Firelands Physician Group

Authorization to Release Copies of a Medical Record

Release of Information Department

I HEREBY AUTHORIZE RECORDS FROM:

☐ **Firelands Regional Medical Center**
1111 Hayes Ave., Sandusky, OH 44870
Phone: 419-557-7435
Fax: 419-557-5738
(Hospital Records Only)

☐ **North Coast Professional Group, LLC, dba Firelands Physician Group**
1111 Hayes Ave., Sandusky, OH 44870
Phone: 419-557-5552
Fax: 419-557-7872
(Physician Office Records Only)

Patient Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 of SS# _____

City/State/Zip: _____ Phone: _____

Email Address: _____ Fax: _____

I hereby authorize records FROM:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

To be released TO:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Purpose of release/disclosure: ☐ Continuity of Care ☐ Request of Patient ☐ Other (Please Specify) _____

_____ Treatment Date (s): _____

Information to be released: (check all that apply)

☐ Discharge Summary ☐ Emergency Department Report ☐ Radiology / Ultrasound Reports ☐ Operative Reports

☐ History & Physical ☐ Physician Office Notes ☐ Laboratory Reports ☐ Psychiatric Health Record ☐ Other:_____

Information to be: ☐ Emailed ☐ Mailed ☐ Paper Copy ☐ CD

I, the undersigned, authorize Firelands Regional Health System and its agents/employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immunodeficiency Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA/Release of Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization. I understand there may be charges for the copying and release of Information and I accept financial responsibility.

Patient or Person Authorized to Consent: _____ Date: _____

Signature _____ Relationship to Patient _____