

Authorization for release of Information

Patient Name: _____ DOB: _____

_____ (Name of primary care physician) is authorized to release protected health information about the above named patient to the entities named below.

Entity to receive information:

Southern Ohio Green Med
Phone: (740)777-6610 Fax: (740)835-5150
Email: Records@SouthernOhioGreenMed.com

Description of information to be released:

- Office notes, referrals, physical therapy, psychiatric notes, labs and imaging related to one or more of the 21 qualifying conditions listed here: AIDS, amyotrophic lateral sclerosis, Alzheimer's disease, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, pain that is either chronic and severe or intractable, Parkinson's disease, positive status for HIV, post-traumatic stress disorder, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury, and ulcerative colitis.
- Notes of treatments tried in past and current treatment of the condition are also requested.
- The physician may also write a summary on their letterhead if they would like and include supporting documentation.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documentation)