Summa Health™

Medical Group

Authorization for Release of Patient Health Information

Patient Name	Last	First	Middle
Last 4 digits of SS#		Date of Birth	
Address			
City		State	Zip Code

The undersigned hereby authorize	Name of Person or Organization	
Street		Phone Number
City	State	Zip Code

Release Information to	Name of Person/Organization/Practice	
Street		Phone Number
City	State	Zip Code

Purpose of Disclosure

○ Billing ○ Research ○ Personal
○ Fund Raising ○ Legal ○ Marketing
○ Health Care ○ Other_____

Specific Information to be Released

○ Entire Record ○ Progress Notes ○ History & Physical
○ Lab Report ○ Radiology Report ○ Imaging Report
○ EKG Report ○ Cardiac Cath Report ○ Operative Report
○ Discharge Summary ○ Other_____

I understand that the information contained in my records may include information related to sexually transmitted disease, AIDS/HIV, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I am not required to sign this authorization form and that the health care provider named above will not condition the provision of treatment or payment to me on the signing of this authorization, except that the health care provider named above may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. The health care provider named above may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by the federal policy regulations.

I understand that I may revoke this authorization at any time by notifying the health care provider named above in writing, except to the extent that 1) action has been taken in reliance on this authorization; or 2) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

This authorization will remain valid for one year from the date of execution.

_____ _____ _____
Signature of Patient Date Time

_____
Printed name of Patient or Legal Representative

_____ _____ _____
Signature of Patient's Legal Representive Date Time

○ Guardian ○ POA ○ Executor ○ Person Responsible for Estate