Cleveland Clinic

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Chagrin Falls Family Health Center
551 East Washington St.
Chagrin Falls, Ohio 44022

440/893-9393
800/232-0263
Fax: 440/893-6345

Patient:_____ SS#:_____

Clinic#:_____ Date of Birth: _____/_____/_____

Telephone #:_____ Current Address: _____

City:_____ State:_____ Zip:_____

I hereby authorize the Cleveland Clinic to release the health information indicated below that is contained in my patient records to the Recipient named below. **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 as defined below.* The release of Psychotherapy Notes requires a separate authorization.**

Name of Recipient: RECORDS DEPOSITION SERVICE, INC. (please print) Telephone: 248-357-3330
FAX: 248-357-3337

Street: P.O. BOX 5054

City: SOUTHFIELD State: MI ZIP: 48086-5054

Reason for Disclosure: FOR DISCOVERY BEFORE TRIAL
(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment: _____

Please list additional Cleveland Clinic locations if needed:

	Emergency Department Reports		Pathology Reports		Cleveland Clinic Family Health Centers (list locations below):
	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.** I understand that the recipient of my health information may be charged for the service of releasing medical information. 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

**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*

***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.*