TriHealth
Occupational Medicine Centers

☐ Bethesda Care Arrow Springs
Phone: 513-282-7075
Fax: 513-282-7076

☐ Bethesda Care Blue Ash
Phone: 513-791-4040
Fax: 513-791-2916

☐ Bethesda Care Butler Cty
Phone: 513-874-3990
Fax: 513-860-5071

☐ Bethesda Care Eastgate
Phone: 513-752-3695
Fax: 513-752-3039

☐ Good Samaritan
Phone: 513-872-2875
Fax: 513-872-2860

☐ Bethesda Care Norwood
Phone: 513-731-3399
Fax: 513-731-2882

☐ Bethesda Care Queensgate
Phone: 513-241-4135
Fax: 513-241-6510

☐ Bethesda Care Sharonville
Phone: 513-563-1505
Fax: 513-769-4776

REQUEST FOR RELEASE OF RECORDS
FOR TREATMENT PURPOSES

I, _____(patient name), hereby authorize **BETHESDA CARE SHARONVILLE** to release my individually identifiable health information to Bethesda Healthcare, Inc.

The following individually identifiable health information may be used and/or disclosed. *Check (√) all that apply:*

☐ All Records
☐ History and Physical Records
☐ Results of Physical Examination Form
☐ Reports of Tests and X-rays
☐ Immunization (shot) Record
☐ Discharge Forms
☐ Emergency Treatment
☐ Progress Notes
☐ Consultation Reports
☐ Physical Therapy Notes
☐ Billing Records, including Itemized Statements
☐ Other: _____

Dates of Treatment/Medical Examination or Service to be released. *Check (√) only one box.*

☐ All treatment/examination dates
☐ Other (please specify): _____

I authorize the following person(s) or organization to receive the information:

Name/Organization: **RECORDS DEPOSITION SERVICE, INC.**
Street Address: **PO BOX 5054** **P: 248.357.3330**
City, State, and Zip Code: **SOUTHFIELD, MI 48086-5054** **F: 248.357.3337**

I authorize the release of any information contained in the records checked above including treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed name of patient's representative, if applicable Relationship to Patient