



5900 N Main St #3 Dayton, OH 45415
 www.shilohfamilymedicine.org
 937-277-9371

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:				<input type="checkbox"/> PREVIOUSLY DR CLACK'S PATIENT	
LAST NAME		FIRST		MIDDLE	
ADDRESS		CITY		STATE	ZIP
DOB	SSN	EMAIL		PREFERRED PHONE	<input type="checkbox"/> OK TO LEAVE MESSAGE
RECORDS RELEASED TO:					
SHILOH FAMILY MEDICINE 5900 N MAIN ST #3 DAYTON, OH 45415		937-277-9371 PHONE 937-277-7734 FAX		EDWARD CLACK DO MBA ERIC NORDIN DO	
RECORDS RELEASED FROM:					
NAME OF PREVIOUS DOCTOR				PHONE NUMBER	
PRACTICE ADDRESS		CITY		STATE	ZIP
RECORDS TO BE RELEASED:					
<input type="checkbox"/> ALL RECORDS	<input type="checkbox"/> LAB REPORTS	<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> OTHER:		
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> CONSULTATIONS	<input type="checkbox"/> EMERGENCY RECORDS			
<input type="checkbox"/> MEDICATIONS	<input type="checkbox"/> OPERATIVE REPORTS	<input type="checkbox"/> IMMUNIZATIONS			
<input type="checkbox"/> PATHOLOGY	<input type="checkbox"/> THERAPY NOTES				
DATES OF SERVICE TO RELEASE:					
FROM			TO		
AUTHORIZATION AND EXPIRATION:					
<p><input checked="" type="checkbox"/> I understand this information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR part 2) may prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal law.</p> <p><input checked="" type="checkbox"/> I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS related conditions, sexually transmitted diseases and/or alcohol/drug abuse.</p> <p><input checked="" type="checkbox"/> This authorization will expire one year from date for Ohio & Kentucky and 60 days from date for Michigan.</p> <p><input checked="" type="checkbox"/> I understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the right to the insurers to contest a claim under policy</p> <p><input checked="" type="checkbox"/> I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are stated in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.</p> <p><input checked="" type="checkbox"/> I understand that my medical records cannot be released unless I sign this form.</p> <p><input checked="" type="checkbox"/> There may be a charge for copies of records.</p>					
SIGNATURE:					
SIGNATURE OF PATIENT				DATE	
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PARENT				DATE	
RELATIONSHIP TO PATIENT					