SHILOH
FAMILY MEDICINE

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

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM

PATIENT INFORMATION:				❑ PREVIOUSLY DR CLACK'S PATIENT
LAST NAME	FIRST	MIDDLE	MAIDEN	
ADDRESS	CITY	STATE	ZIP	
DOB	SSN	EMAIL	PREFERRED PHONE	❑ OK TO LEAVE MESSAGE

RECORDS RELEASED TO:		
EDWARD CLACK DO MBA SHILOH FAMILY MEDICINE	5900 N MAIN ST #3 DAYTON, OH 45415	937-277-9371 PHONE 937-277-7734 FAX

RECORDS RELEASED FROM:			
NAME OF PREVIOUS DOCTOR		PHONE NUMBER	
PRACTICE ADDRESS	CITY	STATE	ZIP

RECORDS TO BE RELEASED:				
❑ **ALL RECORDS** ❑ HISTORY & PHYSICAL	❑ MEDICATIONS ❑ PATHOLOGY ❑ LAB REPORTS	❑ CONSULTATIONS ❑ OPERATIVE REPORTS ❑ THERAPY NOTES	❑ DISCHARGE SUMMARY ❑ EMERGENCY RECORDS ❑ IMMUNIZATIONS	❑ OTHER:

DATES OF SERVICE TO RELEASE:	
FROM	TO

AUTHORIZATION AND EXPIRATION:

- ✓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.
- ✓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.
- ✓This authorization will expire one year from date for Ohio & Kentucky and 60 days from date for Michigan.
- ✓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
- ✓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.
- ✓I understand that my medical records cannot be released unless I sign this form.
- ✓There may be a charge for copies of records.

SIGNATURE:	
SIGNATURE OF PATIENT	DATE
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PARENT	DATE
RELATIONSHIP TO PATIENT	