AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Print Patient Name ______________________________ Date ____________________

To: Ohio Surgery Center
(Name of Institution Holding Records)
930 Bethel Rd.
Columbus, Ohio 43214

I AUTHORIZE YOU TO RELEASE RECORDS TO: ______________________________

Address ______________________________

City ______________________________ State ____________ Zip ____________

FOR THE PURPOSE OF: ______________________________
(Reason for Releasing Information)

Release the following portion(s) of patient's medical record during the time period of ____________

Discharge Summary	☐	Physician's Orders	☐	ECG Report	☐
Nurse's Notes	☐	X-Ray Report	☐	Other ____________	
Entire Medical Record	☐	Pathology Report	☐	____________	
Lab Report	☐	Progress Notes	☐	____________	
Operative Record	☐	History & Physical Report	☐	____________	

This authorization will remain in effect for six months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by patient at any time, but it is NOT retroactive to release of information made in good faith.

By signing this authorization, the undersigned agrees NOT to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent or authorization.

Proposed new use of information without additional written consent of the person to whom it pertains is prohibited.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that if there is a charge for copies, that such charges must be paid prior to release of copies.

Signed ______________________________
(Patient/Responsible Party)

Signed ______________________________
(Signature of Witness)

Address ______________________________

City ______________________________

State ____________ Zip ____________

Patient's Birthdate ____________________

MR-F4