Canton Women's Center
PO BOX 2217 WESTERVILLE, OH 43086
FAX: 330-966-9030

Authorization for Release of Protected Health Information

I, _____, _____/_____/_____ , _____/_____/_____ ,
(Patient Name) (Date of Birth) (Social Security Number)

(_____)_____-_____, _____
(Phone Number) (Address)

Authorize the Canton Women's Center to **disclose to / request from** the following person/entity, the protected health information described below in accordance with this authorization:

_____
Name of other person/entity FAX NUMBER

_____
Street Address City State Zip

PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

I authorize the following individually identifiable health information to be disclosed:

[ ] Entire medical record [ ] Test Results _____
[ ] Pertinent Summary [ ] Other _____
_____

INFORMATION WILL BE USED/DISCLOSED FOR THE FOLLOWING PURPOSE:

_____ Continued Treatment _____ Personal Use _____ Other _____

I understand and authorize that my medical record may contain alcohol/drug and or Human Immune Virus, Acquired Immune Deficiency Syndrome and/or mental health information and I expressly consent to the release of any such information contained in the records designated above. I also understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _____(**initial**)

This information has been disclosed to you from confidential records protected from disclosure by State/Federal Law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by State/Federal Law.

This authorization for release of information is valid for 60 days from the date of signature, unless revoked in by written notice to the providing facility, providing said notice is received prior to release of information.

_____ _____
Printed Patient Name Date

_____ _____
Signature of Patient or Authorized Representative Relationship to Patient