Authorization for Release of Medical Information

Patient Name: ____ Last 4 SS# ______________

Date of Birth: ______________________________ Phone: (______) ______________ ____________

Address: ____

City: ___________________________________ State: _____________ Zip: ______________

Reason for Disclosure: ____

Release From:

MILLTOWN FAMILY PHYSICIANS, INC.
128 East Milltown Road, Suite 105
Wooster, Ohio 44691
(330) 345-8060

The type and amount of information to be used or disclosed is as follows: (include dates when appropriate)

______ Complete Health Record
______ Lab Results/ Radiology Reports
______ Physical Exam
______ Consultation Reports
______ Immunization Record
______ Other (please specify): ____________________

Send To:

Physician/ Facility Name(s): ____

Address: ______________________________________ City: ______________________

State: _____________ Zip: ____________ Phone: ______________ Fax: ________________

I authorize Milltown Family Physicians Inc. & Athleticare to release the health information indicated above that is contained in my patient record from the above mentioned provider/facility. I understand this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses.

This consent is subject to revocation at any time. This authorization and consent will expire one year from the date of authorization written below. Once your healthcare information is released, a new disclosure of your healthcare information by the recipient may no longer be protected by law.

______________________________ ______________________________
Signature of Patient or Legal Representative | Printed Name

______________________________ ______________________________
Relationship to the Patient | Date