



128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

**Paper copy only please.
No CD's or Flash drives.**

**Greater than 50 pages,
please MAIL all records.
Less than 50 pages, please
FAX to 330-345-0072.**

Authorization for Release of Medical Information

Patient Name: _____ Last 4 SS# _____

Date of Birth: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Reason for Disclosure: _____

**Release To: Milltown Family Physicians, Inc. & Athleticare
128 East Milltown Road, Suite 105
Wooster, Ohio 44691
(330) 345-8060**

Request From:
Physician/ Facility Name(s): _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

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): _____ |

I authorize Milltown Family Physicians Inc. & Athleticare to receive 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