PAPER COPY ONLY
NO CD OR FLASH DRIVE

Greater than 50 pages,
MAIL all records.
Less than 50 pages,
FAX to 330-345-8435

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

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

_____ Immunization Records

_____ Consultation Reports

_____ Colonoscopy/OP report

_____ 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