Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Facility To Which Records are to Be Released:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone or Fax: _____

Released Medical Records from:

Shipley Child Health Clinic, Inc.
919 2nd Street NE
Canton, Ohio 44704
330-453-3386
330-453-2362 (fax)

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it shall include information from the above named facility's records, including photocopies, relating to the patient's identity, diagnosis, prognosis and/or treatment including:

_____Entire Medical Record	_____History and Physical	_____Lab Reports
_____Emergency Dept reports	_____Consultation(S)	_____X-Ray Reports
_____Therapy Reports	_____Immunization Records	_____Newborn Screenings

_____Other _____

This authorization includes the release of information if included in the medical record: AIDS, HIV-related information or testing, psychiatric disorders, drug treatment and/or alcohol treatment. The specific dates of such records to be disclosed include: _____.

I hereby agree to this authorization and understand that it may include Personally Identifiable Information and PHI as defined by HIPPA to ensure accuracy. I understand that I Have the right to limit the type of information released and to revoke this authorization by submitting notice in writing to you. Unless revoked, this authorization will expire on the following date _____. If I choose to limit the information released, I understand that you may inform the requestor that portions of the record have been withheld. You are hereby released from any legal responsibility or liability for disclosure of the information to the extent indicated and authorized herein.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent/Legal Guardian/Authorized Representative Date

_____
Relationship to Patient

_____ _____
Signature of Witness Date