Sara's Garden
620 West Leggett Street • Wauseon, OH 43567 • 419.335.7272 • Fax 419.335.5564 • www.SarasGarden.org

Request for Release of Medical Information

Patient Name: _____ Phone Number: _____

Social Security Number: _____ Date of Birth: _____

1. I authorize the following healthcare provider to disclose and release the requested confidential health information and medical records:
   Healthcare Provider(s)

   Provider Name: _____

   Phone Number: _____ Fax Number: _____

   Requested Medical Information

   ☑ Medication List
   ☑ Most Recent History and Physical
   ☑ Latest Chest X-Ray and CT Imaging Reports
   ☑ Last 4-6 Office Visits
   ◯ Other: _____
   ◯ Date: _____ to Date: _____

2. Health information is to be disclosed to Sara's Garden.

Please mail or fax medical records to:

Sara's Garden • 620 West Leggett Street, Wauseon, OH 43567 • Fax. 419.335.5564

3. I understand the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment or testing for alcohol or drug abuse.
4. This authorization will expire one year from the date appearing at the bottom.
5. I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to the authorized party. I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.
6. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Clinic Director for Sara's Garden.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient: _____

Lori Fredrick MSN, RN
Clinic Director, Sara's Garden