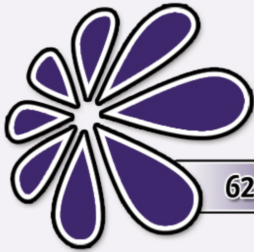

Sara's Garden

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 ____ to disclose the following protected health information about the above-named patient (include dates where appropriate):

   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 information to:

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

3. If I fail to specify, the purpose of this authorization is: Individual's request. Other: ___________________________

4. 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.

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. If I fail to specify, this authorization will expire one year from the date appearing at the bottom. This authorization will expire on the following date, event or condition: ___________________________

7. 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 facilities located at 620 West Leggett Street, Wauseon, OH 43567.

____ ____________________

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient: ______________________________________

Lori Fredrick MSN, RN

Signature of Witness