Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

TO: **Facility or Doctor Name:** _____

Address: _____

_____

_____

Phone: _____

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____ _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically)

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to:

Name: **Michael A. Baker, O.D. and Associates**
Address: **103 N Lake St**
Madison OH 44057
Phone: **(440) 428-2526**
Fax: **(877) 581-6568**

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ Other:

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) | Date

_____ _____

Printed name of patient representative | Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney, executor)*