AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date Of Birth: _____

Address: _____ City: _____ Zip: _____

Phone: _____ S.S. #: _____

I authorize the release of my medical records from:

Physician / facility: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Please send my records to:
Tina Joyce D.O.
8007 Auburn Rd. Suite 3 **Phone Number: 440-375-5520**
Concord, Ohio 44077 **Fax Number: 440-350-0955**

Reason:
____ Transfer of care
____ Share records with PCP

Please release the following (check all that apply):

Recent H & P ___	Last 3 visits____
Lab reports ____	X-Ray Reports____
Hospital Reports ___	Other____

- Please allow 15 days for processing - Incomplete information will delay processing.
- Use of this information other than the intended purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

I authorize the release of HIV/ HTL/AIDS test results □YES □NO Initials_____

I understand that I may be charged for copies provided. Initials_____

Signature of Patient: _____ Date_____

Witness by: _____ Date_____
Note: This consent is valid for 90 days it may be revoked by the signer at any time.

Date when records received: _____ Records reviewed by Dr. Joyce: _____