

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
Concord, Ohio 44077**

Phone Number: 440-375-5520

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: _____

This report contains information which is legally protected under HIPPA legislation. If you have received this communication in error, do not distribute the information any further. Please, immediately notify us at 440-375-5520 and return the original message through the U.S mail to Tina Joyce D.O., LLC at 8007 Auburn Rd. Suite 3, Concord, Ohio 44077.