Lake Health / University Hospitals
Seidman Cancer Center
A joint venture of Lake Health and University Hospitals

9485 Mentor Ave, Suite 3
Mentor, Ohio 44060
(440) 205-5755

Place patient sticker here

Authorization for the Release of Healthcare Information

Patient Name: ______________________________ Date of Birth: __________
Last First Middle Initial FKA/Maiden Name

Address: ______________________________ Telephone: __________
______________________________ SSN#: __________
____

DESCRIPTION OF MEDICAL INFORMATION TO BE RELEASED:

- ❑ **All records (includes all records in file and all noted below)**
- ❑ History/diagnoses and physical(s)
- ❑ Consultation report(s)
- ❑ Emergency Room report(s)
- ❑ Admission report(s)
- ❑ Radiology reports, X-Rays, MRIs, CT scans
- ❑ Operative report(s)
- ❑ Laboratory and pathology report(s)
- ❑ EKG report(s)
- ❑ Discharge summary
- ❑ Other ______________________________

I hereby authorize the facility and/or physicians that have any of my records to provide copies to:

Name: ______________________________

Address: ______________________________
____

Phone: ______________________________ Fax: ______________________________

E-Mail: ______________________________

PURPOSE OF DISCLOSURE: ______________________________ at patient's request

I hereby authorize the disclosing entity and its employees to release information from my medical records described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Deficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol, or drug dependencies/abuse. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected. I understand that I may revoke this authorization at any time by sending a written notice of revocation to both organizations stating that I no longer wish to disclose information about myself. I understand that the revocation will have no effect on information already released in reliance upon this Authorization. Unless otherwise revoked, this Authorization will expire in one (1) year. I understand that treatment, payment enrollment, or eligibility for benefits will not be conditioned on my failure to sign this Authorization.

______________________________ ______________
Signature of patient/authorized representative[1] Date

____
Printed name and relationship to patient (if applicable)

[1] If other than the patient's signature, a copy of legal documents must accompany the authorization when presented; the exception is a parent of a minor under 18 years of age.