

REQUEST FOR NON-CHMC MEDICAL RECORDS

TO: _____

I, the undersigned, hereby authorize _____ to release the following information from my (or give relationship _____) medical record. This authorization includes release of information concerning **HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions.**

The following information may be released or reviewed:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Outpatient Clinic Notes
<input type="checkbox"/> History & Physical Examination	<input type="checkbox"/> (Specify Clinic) _____
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Immunization (Shot) Records
<input type="checkbox"/> Emergency Department Record	<input type="checkbox"/> Other (Specify) _____

Dates of Treatment _____
or Particular Illness _____

The above information is to be released to:

Name and Title of Person _____
Agency/Hospital _____
Street Address _____
City, State and Zip Code _____

The above information is requested to be released for the following purposes only.

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire (60) days after the date below, or sooner by my choice, in which case this consent will expire on _____

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

Patient's Name _____ Signature * _____
Address _____ (of legal guardian)
Relationship _____
Date _____
Birthdate _____ Telephone # _____

* Patient must sign the authorization because he/she is an emancipated minor or the conditions of treatment require signature.