



Euclid Hospital

18901 Lake Shore Blvd.
Euclid, Ohio 44119-9989
Phone 216-531-9000

Authorization for the Release of Protected Health Information

I give permission for Euclid Hospital to:

- Release to Receive from

Name of person/Doctor/Hospital/Facility:

Street: City: State: Zip:

Phone: Fax:

Information to be released:

- Emergency Record Operative Report Consult Report Lab EKG
Discharge Summary Pathology Report Radiology Report History & Physical

Other:

Date(s) of treatment:

Purpose of disclosure: Continuity of care/follow up Personal use Legal
Insurance Disability Other:

Patient Name: SS#: Date of Birth:

Telephone#: Current Address:

This authorization will expire in 60 days unless otherwise stated:

I hereby authorize Euclid Hospital and it's employees the right to release any and all information contained in my medical records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results, diagnosis and/or treatment.

I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to redisclosure by the recipient.

Access to medical information is the right of every patient, duplication and distribution is a service. As a professional courtesy, no cost is assessed for information released directly to your helath care provider; all other releases are subject to costs for copying and distribution.

I understand that I am not required to sign this authorization and may refuse to sign it. I understand that I need not sign this form to ensure healthcare treatment.

Signed: Date:

Patient, Guardian, Administrator, Executor or next of kin (circle one)

If person other than patient signing please include appropriate legal document(s).

Distribution: Original - chart Copy - patient Copy - Requestor