ABODE
CARE PARTNERS

Authorization Release for Medical Records

Patient Information - please fill out completely	
Patient Name:	
Address:	
City/State/Zip:	
Phone Number:	Date of Birth:
Name of Facility Releasing Information:	
Facility to which information will be released: **Abode Care Partners** 26110 Emery Road, Suite 300 Warrensville Heights, OH 44128 **Phone: 1-800-807-6555** **Fax: 855-453-5010**	**Purpose of request:** Treatment, continuity of care
Information Requested	
Progress notes	Radiology/Imaging reports
Consultation reports	Radiology films
Most recent history and physical	Two-way verbal exchange of communication
Immunization record	Entire medical record
Laboratory reports	Other:
Date Range of Information Requested: Start Date / / End date / /	

By signing this authorization, I agree to the following:

- I understand if I authorize my information to be released to persons or organizations not subject to federal privacy laws, the information may be re-disclosed by the recipient and the information will no longer be protected.
- I understand that authorizing the use and disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment.
- I understand that I may inspect a copy of the information to be used or disclosed.
- I understand that I can revoke this authorization at any time by contacting my provider, but any revocation will not apply to the extent that my provider has acted in reliance of this authorization.
- I authorize the use and disclosure of my health information as described above. This authorization expires one year from the date on which it was signed, unless otherwise specified. (Otherwise, specified date, event, or condition:_____)

Signature of Patient/Patient Representative: _____
Date: _____
If Other Than Patient, Printed Name: _____
Relationship to Patient: _____