Community Memorial Hospital

HIM Department
208 North Columbus Street
Hicksville, OH 43526
419-542-5664 (T) 419-542-6440 (F)

HOURS OF OPERATION
M-F 8:00am - 4:30pm
S-S Closed

1. I hereby authorize ☐ CMH and/or ☐ Doctor _____
(FACILITY/PHYSICIAN NAME)

to release my information to: _____

Address: _____
Phone # Fax #

2. Patient's Full Name: _____

Address: _____

Telephone Number: _____ Date of Birth: _____ MRI#: _____
(OFFICE USE)

3. The purpose for which the following information is being requested: _____

4. I authorize the following information to be released from my medical/surgical records:

Date(s) of Service(s): _____

Records authorized to be released are listed below. In the event that the information checked below includes reference to a mental health or drug and/or alcohol condition treatment, or diagnosis, I authorize the release of that information.

Please check (√) the appropriate item(s):

☐ ER Record/Dictation	☐ History and Physical	☐ Progress Notes	☐ EKG(s)	☐ Radiology Films
☐ Discharge Summary	☐ Surgery Report(s)	☐ Labs (incl. HIV)	☐ X-Ray Report(s)	☐ Pathology Report
☐ Entire Record	☐ Medications	☐ Consultation(s)	☐ Other (Please Specify): _____	

I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.

5. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will terminate on the following date, event or condition: _____
If no date, event or condition specified, this authorization will expire after 60 days.

I further understand that I will agree to pay the facility the costs incurred by Community Memorial Hospital in preparing the copy of the requested medical records as allowed by State and Federal guidelines.
I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability or disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and no longer protected by federal law.

I understand that I am entitled to a copy of this authorization.

Printed Name: _____

Patient/Representative Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

FOR FACILITY PERSONNEL ONLY

☐ Patient Identification Verified. Signature: _____ Date: _____ Time: _____
(Hospital Personnel Receiving Form)

Copy fees for patient records: Please allow 1 week for processing.
$3.07 pages 1-10 flat fee
$.64 per page - pages 11-50
$.26 per page - pages 51↑
******Fees must be paid in full before receiving documentation******
DOCUMENTATION PROVIDED DIRECTLY TO YOUR PHYSICIAN AT NO CHARGE

Records to be: Mailed_____ Faxed_____ Picked Up_____