

AUTHORIZATION FOR REQUEST/ RELEASE OF PROTECTED HEALTH INFORMATION

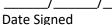
Patient Name:	
Address:C	ityZip:
SS#: Date of Birth:/	/ Telephone#:
Release Information To:	Release Information From:
X Viola Startzman Clinic	Viola Startzman Clinic
Other (list information below)	X Other (list information below)
Name Viola Startzman Clinic	Name
Address 1739 Cleveland Road	Address
_{City} Wooster _{State} OH _{Zip} 44691	City StateZip
Phone#_330-262-2500 Fax#_330-264-8713	Phone#Fax#
Dates of Service to Release (From):(To):	
Office Visits History & Ph	ysical Consultation Reports
Emergency Dep Reports Discharge Su	mmary Lab/Pathology Reports
Operative Reports Radiology Re	eports Other
Reason for Disclosure: Continued Care	Personal Use Other
Request to be: Picked up Mailed	X Faxed #330-264-8713

This authorization is valid for ninety (90) days from the date of signing, at which time this authorization will expire. My consent is extended only for the purpose stated on this authorization. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, any condition related to sexually transmitted diseases, and/or HIV/AIDS test results or diagnoses. I understand I may revoke this authorization in writing, at any time, by sending such written verification to Viola Startzman Clinic, 1874 Cleveland Rd., Wooster, OH 44691. I understand that cancellation does not apply to personal health information disclosed according to this authorization prior to the written cancellation.

I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical records as permitted by law. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If Viola Startzman Clinic is receiving this information, Viola Startzman Clinic will only use or disclose the information as permitted by law or as authorized by you. Your health care will not be affected by whether or not you sign this authorization. I understand that I am knowingly and voluntarily signing this authorization. I understand that I have the right to refuse to sign this authorization. I further understand that I have the right to copy the protected health information to be used or disclosed as permitted by law.

Signature of Patient or Guardian

Printed Name



Relationship (if not patient)

Phone Number