1874 Cleveland Rd., Wooster, OH 44691
330-262-2500 Fax 330-264-8713

AUTHORIZATION FOR REQUEST/ RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:____

Address:______________________ City______________ State_____ Zip:_________

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*________ *State*______ *Zip*________
Phone# 330-262-2500 *Fax#* 330-264-8713	*Phone#*__________ *Fax#*__________

Dates of Service to Release (From):______________________(To):______________________

Office Visits__________	History & Physical________	Consultation Reports__________
Emergency Dep Reports________	Discharge Summary_______	Lab/Pathology Reports__________
Operative Reports________	Radiology Reports________	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	Date Signed
______________________	______________________	
Relationship (if not patient)	Phone Number	