OhioHealth
BELIEVE IN WE™

OhioHealth Primary Care Physicians
Gahanna Primary Care
504 Havens Corner Rd.
Gahanna, OH 43230
Phone #: 614-533-5300
Fax #: 614-533-5350

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: ___/___/_____ Social Security #: __ __ __-__ __-__ __ __ __
(Print Name)

Release Records from: Physician Office, Medical Facility Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone #: _____ Fax #: _____

****PLEASE NOTE: There will be a charge for records released to our practice from your previous physician office. Cost of records release varies per medical facility.**

1. I hereby authorize the release of my medicals records to Gahanna Primary Care (Dr. Keswani, Dr. Lutz). The "Release of Information" of any and all records, reports and charts, including x-rays pertaining to your diagnosis, care, treatment of AIDS, AIDS related conditions, drug/alcohol abuse, psychiatric care or treatment, and or surgery. You are authorized to deliver such information in person, via regular U.S. Mail, or via facsimile transmission. I understand that the information forwarded regular U.S mail or via facsimile may be viewed by someone other than the intended recipient and hereby release you from any liability as a result of such transmission.

2. The information to be released is limited as noted below: If there are no limitations, state "NONE" below:
   _____

3. The above information is released for the following purpose and that/those purposes only. Other use is forbidden.
   - _____ Continuity of medical care
   - _____ Insurance or other third party reimbursement
   - _____ Pending legal action
   - _____ Personal review
   - _____ Other (please specify) _____

4. I understand that numbers 1, 2 and 3 must be complete before record will be released.

- This consent will expire in (60) days after the date below or sooner if I elect to do so in writing.

Patient Signature: _____ Date: _____

Parent/Legal Guardian/Administrator of Estate/Medical Power of Attorney: _____
(Print Name)

Parent/Legal Guardian/Administrator of Estate/Medical Power of Attorney: _____
(Signature)

Date: _____

PROHIBITION OR REDISCLOSURE: The information has been disclosed from the records whose confidentiality is protected by Federal Law. Federal Regulation (42 CRF Part 2) prohibits anyone from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if help by another party, is not sufficient for this purpose.