Diane Eden, MD and Associates Inc.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name: _____ SS#: _____

CC#: _____ Date of Birth: _____

Telephone #: _____ Address: _____

City: _____ State: _____ Zip: _____

Name of Healthcare Facility from which Records are requested to

☐ obtain records from ☐ release records to

_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment Requested: _____

Reason for Disclosure: (_) Continued Care Other:_____

MAIL OR FAX THIS INFORMATION TO OR FROM:

Release Medical Information to: ☐ Diane Eden MD & Associates, Inc
Attention:_____
35000 Chardon Road Suite 210
Willoughby Hills, OH 44094
Phone: (440) 951-5600
Fax: (440) 951-1293

I hereby authorize Diane Eden MD & Associates Inc. to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.

	All Records Available		Pathology Reports
	Discharge Summary		Laboratory Reports
	History & Physical		Radiology Reports
	EKGs		Operative Reports
	Emergency Department Reports		Other (Specify)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire one year from the date of authorization written below.**

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____/_____ _____ _____ _____

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

_____

Relationship if not Patient

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany their request. (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*

1/12 form owned by DEA