AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Specific information to be released:

- ☐ Verbal/Telephone/Written Updates
- ☐ Complete Health Record
- ☐ History and Physical Exam
- ☐ Discharge Summary/Summary of Treatment
- ☐ Laboratory/Radiology/EEG
- ☐ Other _____

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

_____ Social Security #: _____

☐ **I hereby authorize the following person(s) or organization(s):**

Name: _____ City _____ ZIP _____

Address: _____ Phone #: _____

_____ Fax #: _____

to release the above information to:

VINCENT PAOLONE, M.D.
8166 MARKET ST. UNIT B
BOARDMAN, OHIO 44512
Phone: (330) 758-8528 Fax: (330) 758-8529

☐ **I hereby authorize Dr. Vincent Paolone** to release the above information to the following person(s) or organization(s):

Name: _____ City _____ ZIP _____

Address: _____ Phone #: _____

_____ Fax #: _____

I understand this may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), Psychiatric Care (Behavioral Health), or Treatment for Alcohol and/or Drug Abuse. **I understand this** authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked in writing, this authorization will expire 60 days from the date of execution. A photocopy or FAX of this document is valid as the original. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein:

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Witness Signature Date

PROHIBITION ON REDISCLOSURE: This information has been disclosed from records whose confidentiality is protected by federal law. Federal Regulations (42CFR Part2) prohibit the receiver of these records from making any further disclosure of this information except the specific written consent of the person to whom it pertains. A general authorization for the release of the medical or other information if held by other party is not sufficient for this purpose. The patient information requested above may not be further disclosed to any party under any circumstances except with the patient's expressed written consent or as otherwise permitted by law. The information may not be used except for the need specified above.