



Tammy Eisentrout, D.O.
Gina Volpe, D.O.
Gina Jones, C.N.P

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

I, _____, authorize _____
to release my medical records to: (Physician's name with old records)
(Please include a phone # or address)

Partners in Family Practice, Ltd.
Phone: 478-4132
Fax: 330-478-3341

4048 Dressler Rd. N.W. Suite 203
Canton, Ohio 44718

As you may know, the HIPAA Privacy Rule permits a provider who is a covered entity to disclose a complete medical record including portions that were created by another provider, assuming that the disclosure is for a purpose permitted by the Privacy Rule, such as treatment!

The following information is authorized for release (check all appropriate items):

- | | | |
|----------------------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Emergency Room Report(s) | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Complete Medical History | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Other _____ | | |

I understand and acknowledge that my medical records may contain alcohol/drug abuse and/or HIV/AIDS and/or mental health information, and I expressly consent to the release of any such information contained in the records designated above. **This release expires 1 year from the date of signature unless otherwise, indicated by patient.**

Signature of Patient

Date

Signature of Parent/Guardian (Relationship)

Date

Signature of Witness

Date