Youngstown Community Health Center: 726 Wick Ave, Youngstown, OH 44505 | 330-747-9551 | Fax 330-747-2740
Warren West Community Health Center: 716 Tod Ave. SW, Warren OH 44485 | 330-373-0222 | Fax 330-393-3764
Lloyd McCoy Community Health Center: 1977 Niles Rd., Warren, OH 44484 | 330-393-6446 | Fax 330-369-1580
Good Samaritan Community Health Center: 1390 South Arch Ave., Alliance, OH 44601 | 330-821-3961 | Fax 330-821-0232
Kidz 1st Pediatrics: 1821 E. Market St., Warren, OH 44483 | 330-392-7000 | Fax 330-392-0864
Falls Family Care: 175 E. Broad St., Newton Falls, OH 44444 | 330-872-2010 | Fax 330-872-4309
Premier Care Pediatrics: 2642 State Rt. 5 (Medical Building C), Cortland, OH 44410 | 330-841-5500 | Fax 330-841-5510
Northside Dental Center: 500 Gypsy Lane (Medical Building A, Floor 3), Youngstown, OH 44504 | 330-469-2049

ONE HEALTH OHIO: AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Patient_____ Date of Birth_____

I authorize _____

to release to_____

The following information:

___Entire medical record
___Entire mental health record
___Other_____

Records covering services provided
from dates_____ to_____
___All records between these dates
___Lab tests
___Discharge Summary
___Consultation Reports
___Imaging Reports
___Other_____

The purpose of this disclosure is:

___Coordination of care _____Transfer of care *Reason for transfer_____
___Legal Case _____ Requested by Patient, or Guardian/Parent
___Other_____

1) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2) I understand that the party receiving my information might not be subject to HIPAA and might be allowed to disclose this information.
3) The facility releasing the records does not require that I sign this authorization in order to receive services.

Expiration Date:
___90 days from date signed
___1 year from date signed
___other date: _____

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient

For staff use: (complete the following steps and indicate by a check. Name of Staff Person_____)
_____Copy of signed authorization given to Patient/Parent/Guardian
_____Copy of records released given to Patient/Parent/Guardian (if requested)
_____Revocation received on _____and acted upon.

Approved by Medical Records Coordinator: _____