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
Rise Recovery (Youngstown): 3132 Belmont Ave., Youngstown, OH 44505|844-652-8219|Fax 866-793-5728

ONE HEATH OHIO: AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____ authorize _____
Please Print Patient's Name | Date of Birth | Organization Authorized to Release Information

to release the following information:

___Entire Medical Record
___Entire Mental Health Record
___Entire Dental Record
___Other_____
___Lab Tests
___Discharge Summary
___Consultation Reports
___Imaging Reports
___Treatment Plan
___Assessment
___Billing Statements

I would like records covering services provided from dates _____ to _____.

The information may be released to the following individual or organization_____.

Please provide the phone/ fax number, email or address of the person/organization you are granting ONE Health Ohio to release and discuss information with**. Please be advised:** ***Failure to provide at least one method of contact will result in your request being denied.***

Phone Number: _____ Fax Number: _____

Email Address: _____ Mailing Address: _____

The purpose of this disclosure is:

___Coordination of Care
___Transfer of Care
___ Personal Use
___Legal Case
___Other Reason_____

Expiration Date: ___90 days from date signed ___Other date or event_____

If I fail to specify an expiration date, event or condition, this authorization will expire in 1 year from the date signed.

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.

_____ _____
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 or Guardian
_____Revocation received on_____ and acted upon.