

Theodore J. Suchy, D.O. Sanjay K. Patari, M.D. Sheryl L. Lipnick, D.O. Keith L. Komnick, M.D. Brett B. Chamernik

Patient Authorization to Release Medical Information

Patient Name (please print)	Health Record Number	Patient DOB
I authorize (practice/physician	's name) to use or release/disclose my health informati	on as described below.
Please identify the information to be re Please release my entire record -OR- Please release only the following Problem list Medication list List of allergies Immunization records		ther information where indicated):
 ☐ Emergency department re ☐ Operative report ☐ Most recent history and plant of the control of the co	nysical	ed):
X-ray and imaging reports	s (please describe the dates or types of x-rays or images	•
	se supply doctors' names):	
☐ My personal records ☐ Sharing with other healthcare ☐ Other (please describe): Please initial each item below to indicare		
I understand the information in acquired immunodeficiency sy	ne your understanding. In my health record may include information relating to undrome (AIDS), or human immunodeficiency virus (Hilth services and for treatment for alcohol and drug abu	IIV). It may also include information
	ion is released, it may be re-disclosed by the recipient	
writing and present my writter already been released in respon	evoke this authorization at any time. I understand if I represent to the practice. I understand the revocation use to this authorization. I understand the revocation where with the right to contest a claim under my policy.	will not apply to information that has
	te or release of this information is voluntary. I need not t, enrollment, or eligibility for benefits may not be cond	
The identified information may be used Name:	by or released to the following individual(s) or organize Name:	zation(s):
Address:		
mote of the state of the state of	date or event):event, this authorization will expire twelve (12) months	s from the date on which it was signed.
	Legal Guardian	Date
		Date



Medical Records Request / Form Completion Receipt

		330 Patient Copy of	Medical record	
		S25 Additional Cop	y of X-Ray Disk (initial disk is free	of charge)
	Form completion is charged out \$40 per form per diagnosis/disal period. Each additional form/diagnosis/disability period will charged additionally.			
	c	540 One Diagnosis/ overs 12 months of form form/diagnosis will be cha		
		•	diagnosis completion	
			person completing form)	Date
Relationship to Patie	nt (circle one):	Patient Legal Gu	nardian Other:	
Witness Signature		Date	Physician Signature	Date
For Office Use O	only		For Office Use Only	For Office Use Only
Ac	ct #	Diagnosis: _		
То	tal Charged	Amount:		
		Amount:		
		Amount:		
		Received By:	Staff Name Date	
То	tal Payment	Received By:	Staff Name Date Cash Check Credit Card	
To Da	tal Payment	Received By:	Staff Name Date Cash Check Credit Card	