FULTON COUNTY HEALTH CENTER
Completing the circle of care

Mailing Address: Fulton County Health Center
Release of Information Unit – Health Information Department
725 S. Shoop Avenue
Wauseon OH 43567
Phone: 419-330-2662 **Fax:** 419-330-2616

General Authorization for Release of Information

Patient Name: _____ Hospital ID No: H _____

Patient Date of Birth: _____ Social Security No: _____

By signing this authorization form, you are agreeing to the release or disclosure of your protected health information. You will not be refused treatment by Fulton County Health Center if you do not complete this authorization. This authorization will be honored, if presented within one (1) year after it is signed, unless you choose to revoke or cancel this authorization prior to that time. You may revoke this authorization by submitting a request in writing to the address listed above, unless we have previously acted in reliance of the authorization. Please be aware that any information that is disclosed to a third party pursuant to this authorization may be subject to redisclosure and no longer protected by Fulton County Health Center's policies and applicable law. Copying fees may be assessed as allowed per the Ohio Revised Code.

I hereby authorize Fulton County Health Center and its employees to release protected health information about me or my child which may include test results, diagnosis, treatment or other information about HIV or other communicable disease, alcohol and drug information protected by Federal Regulation (42CFR Part 2), and behavioral or mental health information, if any.

Information to be disclosed:

_____ Outpatient Surgery Date(s) of Service: _____
_____ Inpatient/Observation Stay Date(s) of Service: _____
_____ Clinic or Office Visit Date(s) of Service: _____
_____ Emergency Department Visit Date(s) of Service: _____
_____ Other (must specify): _____ Date(s) of Service: _____

Specific reports to be disclosed (check all that apply):

_____ History & Physical _____ Laboratory Report _____ Physician Orders
_____ Operative Report _____ Pathology Report _____ Progress Notes
_____ Discharge Summary _____ Radiology/Ultrasound Report _____ Emergency Department Report
_____ Other (must specify): _____

Purpose of Disclosure:

_____ Continuation of care _____ Request of Patient Other (must specify): _____

Method of Disclosure:

_____ Copied & Faxed _____ Copied & Mailed _____ Copied & Picked Up _____ Viewed

Recipient Information:

Recipient Name: _____
Recipient Address: _____
_____
Date or Condition of Expiration: _____

Signed: _____ _____ _____ _____
(Patient or Person Authorized to Consent) *Date* *Witness (required)* *Date*

_____
(Relationship to patient and authority to act in the patient's behalf)
