Fulton County Health Center
Completing the circle of care

Mailing Address: Fulton County Health Center
Release of Information – 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 Account #:_____

Patient DOB:_____ Social Security #:_____

Phone #:_____

I hereby authorize Fulton County Health Center and its employees to release protected health information for the patient listed above. The information may include test results, diagnosis, treatment or other information about HIV or other communicable diseases, alcohol and drug information protected by Federal Regulation (42CFR Part 2), and behavioral or mental health information, if any.

Release Medical Information to the following recipient:

Name of person/
Organization: _____ Phone Number: _____
Address: _____ Fax Number: _____
_____ Email: _____

Treatment Dates: _____

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 Room Report
_____Physical Therapy	_____Facesheet/Demographics	_____EKG Report
_____Consultation Report	_____Entire Record	

_____Other (must specify):_____

Purpose of Disclosure:

_____Continuation of Care _____Request of Patient Other (must specify):_____

Method of Disclosure:

_____ Printed and Faxed _____ Printed and Mailed _____Printed and Picked up
_____ Secure Email _____ Viewed (by appointment only)

- 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.
- You may choose to revoke or cancel this authorization at any time by submitting a request in writing to the address listed above. Revocation will not apply to the information that has already been released in response to this authorization.
- Please be aware that information that is disclosed to a third party as a result of this authorization may be subject to re-disclosure and is 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.
- In accordance with state law, this authorization is valid for one year from the date of the signature, unless otherwise revoked or specified here: date/condition/event:_____

X_____ ___/___/___ _____
Signature of Patient/Legal Representative** Date Signed Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; the exception is a parent of minors under 18 years of age.


ROI