AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name: _____ Date of Birth:_____/_____/_____

MRN_____Telephone _____

Address_____ City_____State_____Zip_____

Name of Healthcare Facility from which Records are Requested

Reason for Disclosure: **Second Opinion**

Name _____ Dates of Treatment Requested _____

Address _____ FAX: _____

City_____ Office Phone: _____

State_____Country_____Zip/Postal Code_____

I hereby authorize Cleveland Clinic and/or CCAW JV, LLC to obtain the health information indicated below that is contained in my patient records to the Medical Facility named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy notes requires a separate authorization. Psychotherapy notes are defined as notes that document private, joint, group, or family counseling sessions that are separate from the rest of a patient's medical record.

☐	Discharge Summary	☐	MRI, MRA, CTA, CT scans, PET scan,
☐	EEG Report	☐	Cardiac Catheterization / Other Angiograms
☐	Echocardiogram / Ultrasound	☐	Radiology Reports
☐	Pathology Reports and Slides	☐	Laboratory Reports
☐	EKG	☐	Operative Reports
☐	Other (Specify)	☐	H & P

This consent is subject to revocation at any time except the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health information is released, re-disclosure of your health care information by the Recipient may no longer be protected by law.

_____ _____

Signature of Patient/Patient's Representative*** Printed Name Date Signed

_____

Relationship if Not Patient

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care.) For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signed for patient under the age of 18.

**For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Cort must accompany an authorization signed by the name individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

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