Kent State University Health Services
Health Information Management System
Phone: 330-672-8249 – Fax: 330-672-2272
1500 Eastway Drive -Kent, OH 44242

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Patient's Name: _____ Date of Birth: _____
Address: _____
City/State/Zip: _____
SSN#: _____ Patient's Phone#: _____
E-mail: _____

Check Appropriate Box

☐ I authorize the University Health Service (UHS) to **OBTAIN** information from:	**OR**	☐ I authorize the University Health Service (UHS) To **RELEASE** information to:
Name of Provider or Facility		Name of Person, Provider, or Facility
Address		Address
City/State/Zip		City/State/Zip
Phone # (include area code)		Phone # (include area code)
Fax#:		Fax#:

PURPOSE FOR THIS REQUEST: (CHECK ONE) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Continuity of Care ☐ Transfer of Care ☐ Legal ☐ Other

Check Item(s) Needed Below ☐ **Mail** ☐ **Pick Up** ☐ **Fax**

Information to be requested/released			**Date(s) of Service**
□ Office Visit Notes	□ Emergency/Urgent Care Visit	□ HIV-Related Information	From: _____
□ Physical Exam	□ Radiology Reports	□ Alcohol/Drug Abuse-Related	
□ GYN Records	□ Immunizations	□ Other: _____	To: _____
□ Laboratory Tests	□ Physical Therapy Notes	_____	
□ Complete Chart	□ Verification of Visit	_____	

I understand that fees start at $1.00 per page for records consisting of more than 3 pages. There is no charge for copies of immunization records or TB skin test results. I understand that all fees must be paid in advance.

Release format: _____Written _____Verbal

- This release will expire in 90 days.
- This consent for release does not extend to records pertaining to **Psychological Services**.
- I understand that I sign this form voluntarily and that I may change my mind at any time.
- A copy of this form is as valid as the original.

Signature: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.
ROI-7/13 dm/revised7/14/2014

ADMINISTRATIVE:

To be completed by an employee of the University Health Service

Date Request Received: _____ **Received by:** _____

Circle One: **Records Mailed** **Records Picked Up** **Records Faxed** **Records Denied**

Charge: _____ Correspondence Received: _____

Employee Signature: _____ Date Request Completed: _____