



# Henry County Family Physicians Inc.

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## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_, authorize  
Print First Middle Initial Maiden Last Date of Birth

Physician: \_\_\_\_\_  
Physician Obtaining Records From

Address: \_\_\_\_\_  
\_\_\_\_\_

To Release the following PHI from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ All Records                      \_\_\_\_\_ Lab Reports  
\_\_\_\_\_ Office Visit Notes              \_\_\_\_\_ X-Ray Reports  
\_\_\_\_\_ Hospital Reports                 \_\_\_\_\_ Other \_\_\_\_\_

To: \_\_\_\_\_ Dr. Bidwell    \_\_\_\_\_ Dr. Fritz    \_\_\_\_\_ Dr. Knipe  
\_\_\_\_\_ Dr. McMaster    \_\_\_\_\_ Julie Thomas, CNP

Send Records to: **Henry County Family Physicians**                      or Fax to: **419-264-5851**  
**106 North Wilhelm, P.O. Box 52**  
**Holgate, OH 43527**

### Consent:

*I authorize the release of all information indicated, and I am aware that the records release may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol use/abuse, HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome). This authorization is valid for 90 days. It may be revoked by the signer. I understand that I am responsible for any charges associated with copying these records. I understand that it may take up to 10 business days to complete the record transfer. The use of this information for any other use than the stated purpose is prohibited. This information is for the use of the designated recipient only and cannot be provided to any other agency.*

Signature of Patient, Parent, Guardian, or Patient Representative (circle one):

\_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_