MEDICAL RECORDS RELEASE

I, the undersigned, hereby authorize the physicians listed below to release the following information from my medical records to Internal Medicine of Blue Ash. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychological condition and HIV related conditions. Review of the records is also authorized.

The following information may be released and/or reviewed:

___ Office visit notes
___ X-ray & diagnostic reports
___ Immunization records
___ Operative reports
___ Discharge summaries
___ Report of laboratory tests
___ History and Physical exams
___ Consultation reports
___ Emergency room records
___ other: _____

The above information is to be forwarded to:
INTERNAL MEDICINE OF BLUE ASH
9330 KENWOOD ROAD
CINCINNATI, OH 45242

Prohibition on re-disclosure: This information is being disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation prohibits you from making further disclosure of this information except with the specific written consent of the person to whom it pertains.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records as stated above.

Patient Name: _____ Signature: _____
Address: _____
Birth date: _____ Date: _____

Patient is unable to sign because he/she is an emancipated minor, ____ years of age, or for the following reasons:
_____

Signature of relative or legal guardian_____
Witness signature: _____
Relationship to patient: _____ Date: _____

Physician(s) or Facility(s) to request information from:

_____	_____	_____
Name of Dr./facility	Street address	City, State, Zip code
_____	_____	_____
Name of Dr./facility	Street address	City, State, Zip code
_____	_____	_____
Name of Dr./facility	Street address	City, State, Zip code