

Last	First	MI
ID#	(Place patient label here)	

Please print. Incomplete forms will not be processed. See reverse side for instructions and fees.

Name _____
Last First Middle Initial Maiden/Other

Date of Birth ____/____/____ Preferred Phone Number _____
Month Day Year

Fax Number **OR** Email

INSTRUCTIONS

All sections must be completed in their entirety.

- 1. Patient Information:** Complete the entire section to clearly and legibly identify patient - entire patient name (and any previous names), date of birth and phone number.
- 2. Receiving Party:** Identify the full name/organization, address, phone and fax number of the recipient of your health information. Please allow 7-10 days for processing.
 - Select only one: Do you want SHS to release information? **OR** Do you want SHS to obtain information?
 - If the requested release will be made by mail, provide the complete address.
 - If the requested release will be made by fax, provide the fax number.
 - If the requested release will be made by email, please provide the email address.
- 3. Information to be Released:** Be very specific about the information you need released. For example, types of visits or the name of the physician or provider who treated you.
- 4. Dates to be Released:** This can be a very specific date or more general. For example, July 15, 2012 or June 2012 - Feb 2013. You may not request future dates of service. For example, if you complete this form on June 1, 2014, you may not authorize the release of progress notes from an appointment that is scheduled on June 30, 2014.
- 5. Method of Release:** How will your information be delivered? Select only one method and be sure to provide address, fax number or email address in section number **2** (see above).
- 6. Purpose of Release:** Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).
- 7. Rights/Signature:** Your **handwritten** signature and date of form completion are required.

FEE SCHEDULE (In accordance with Ohio Revised Code 3701.742)

Physician/Healthcare Facility: (Records must be mailed/faxed to the provider listed)	No Charge
Personal Copy: (No charge for copies of immunization records)	\$8.00
Third Party: (Not related to continuing care)	\$8.00
Attorney and Insurance Company: (Including subpoenas/excluding claims processing)	\$24.58 records search fee \$1.62/per page (pages 1 – 10) \$0.84/per page (pages 11 – 50) \$0.33/per page (pages 51+)
Radiology and Dental Films: (No charge when requested by a physician)	\$2.62/per film