

Olentangy Private Internal Medicine

Release of Medical Information

I, _____, hereby authorize _____
(Patient) (Release From)

(Physician's Address or phone number)

To release copies of medical records and other information concerning my diagnosis and treatment, including, but not limited to information concerning treatment of drug or alcohol abuse, alcoholism, drug related conditions, HIV testing or treatment or HIV related conditions, psychiatric/psychological conditions. Review of records is also authorized.

The following information may be released or reviewed:

- Case Summary
- Doctors orders and Progress Notes
- History and Physical Exam
- Lab work, x-ray reports and other testing
- Consultations
- Other

The above information is released to:

Dr. Ronald L. Miller
Olentangy Private Internal Medicine
3650 Olentangy River Road, Suite 302
Columbus, Ohio 43214
Phone number: 614-884-0190
Fax number: 614-884-0192

Purpose for Disclosure: _____

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC CONSENT OF THE PERSON TO WHOM IT PERTAINS.

This statement must be signed and dated and may be revoked at any time to the extent action has been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case the consent will expire on _____.

Patient's Name

Signature of Patient

Address

Other person legally authorized to give consent

Birth Date

Relationship to patient and reason

Witness

Today's Date

This information is being disclosed to the above individual/organization for the above stated purpose from records whose confidentiality may be protected by Federal Law.