Hillcrest Hospital
a Cleveland Clinic hospital

6780 Mayfield Road
Mayfield Heights, Ohio 44124
(PHONE) 440-312-4544
(FAX) 440-312-4594

Authorization for the Release of Protected Health Information

I give permission for Hillcrest Hospital to:

☐ Release to ☐ Receive from

Name of person/Doctor/Hospital/Facility:_____

Street:_____ City:_____ State:_____ Zip:_____

Phone: ( )_____ Fax: ( )_____

Information to be released:

☐ Emergency Record ☐ Operative Report ☐ Consult Report ☐ Lab ☐ EKG
☐ Discharge Summary ☐ Pathology Report ☐ Radiology Report ☐ History & Physical

Other:_____

Date(s) of treatment:_____

Purpose of disclosure: ☐ Continuity of care/follow up ☐ Personal use ☐ Legal
☐ Insurance ☐ Disability ☐ Other:_____

Patient Name:_____ SS#:_____ Date of Birth:_____

Telephone#: ( )_____ Current Address:_____

This authorization will expire in 60 days unless otherwise stated:_____

I hereby authorize Hillcrest Hospital and it's employees the right to release any and all information contained in my medical records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results, diagnosis and/or treatment.

I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to redisclosure by the recipient.

Access to medical information is the right of every patient, duplication and distribution is a service. As a professional courtesy, no cost is assessed for information released directly to your health care provider; all other releases are subject to costs for copying and distribution.

I understand that I am not required to sign this authorization and may refuse to sign it. I understand that I need not sign this form to ensure healthcare treatment.

Signed:_____ Date:_____
Patient, Guardian, Administrator or Executor (circle one)

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*

Distribution: ☐ Original - chart ☐ Copy - patient ☐ Copy - Requestor

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