SUMMA Health System

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT NAME	LAST	FIRST	MIDDLE
SOCIAL SECURITY NUMBER		DATE OF BIRTH	
I THE UNDERSIGNED HEREBY AUTHORIZE:	SUMMA HEALTH SYSTEM HOSPITALS / CUYAHOGA FALLS GENERAL HOSPITAL		
TO PROVIDE: *(Name of Person or Organization)*			
NAME:			
STREET:			
CITY:	STATE:	ZIP CODE:	

FOR THE FOLLOWING DATES OF SERVICE / TREATMENT: _____

PURPOSE OF DISCLOSURE: _____

- ☐ Billing _____ expires 60 days from signature
- ☐ Personal _____ expires 60 days from signature
- ☐ Legal _____ expires 60 days from signature
- ☐ HealthCare _____ expires 60 days from signature
- ☐ Research _____ duration of study
- ☐ Fund Raising _____ unless opt out, no expiration
- ☐ Marketing _____ unless opt out, no expiration
- ☐ Other _____

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse.

I understand that I am not required to sign this authorization form and that Summa Health System Hospitals/Cuyahoga Falls General Hospital will not condition the provision of treatment or payment to me on the signing of this authorization, except that Summa Health/Cuyahoga Falls General Hospital may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my personal health information for such research. Summa Health/Cuyahoga Falls General Hospital may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE

☐ Pertinent Summary (includes all * items below if contained in the record)

☐ Admission Form	☐ *Special Procedure	☐ Respiratory Report
☐ *Facesheet	☐ *Pathology Report	☐ Medications / Treatment Report
☐ *Discharge Summary	☐ *Cardiac Cath Report	☐ Nurses Notes
☐ *Emergency Room Report	☐ *Lab Reports	☐ Entire Record
☐ *History & Physical	☐ *Radiology Report	☐ Other: _____
☐ *Consultation Record	☐ *EKG Report	☐
☐ *Operative Report	☐ *EEG Report	☐