Nager, Romaine & Schneiberg Co., L.P.A.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____
Health Record Number: _____
Date of Birth: _____
Social Security Number: _____

1. I authorize the use or disclosure of the above named individuals health information as described below:

2. The following individual or organization is authorized to make the disclosure:

_____

_____

3. Description of information being disclosed for the following date(s) of service:

_____

- ☐ Complete health record
- ☐ Emergency department records
- ☐ Medication list
- ☐ History and physical exam
- ☐ Discharge summary
- ☐ X-ray, imaging and other reports
- ☐ Consultation reports from (doctors' names) _____
- ☐ Other _____
- ☐ Itemized bill for services
- ☐ Progress notes
- ☐ Physical therapy treatment record/notes
- ☐ Laboratory results
- ☐ Drug and alcohol treatment information
- ☐ Surgical reports

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Nager, Romaine & Schneiberg Co., L.P.A.
27730 Euclid Avenue
Cleveland, OH 44132

for the purpose of: LEGAL REPRESENTATION.

Please provide CERTIFIED copies of the requested documents.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: TERMINATION OF MY LEGAL REPRESENTATION BY NAGER, ROMAINE & SCHNEIBERG CO., L.P.A.. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A COPY AND/OR FACSIMILE OF MY SIGNATURE IS AS AN ORIGINAL.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

Please provide CERTIFIED copies of the requested documents.