CHI CLEVELAND HEALTH INSTITUTE

Authorization for Release of Medical Information

I, _____, authorize the release of the medical records of:

Patient Name_____

Patient Date of Birth_____

For the time period of _____ to _____

For health care provided by _____
This includes office notes, labs, x-rays, studies, procedures and pathology or any medical care pertinent to the care of this patient.

For the purposes of coordination of medical care.

I understand that this authorization shall be valid until I revoke this consent in writing or IWCH is relieved of the responsibility of coordination of care on behalf of the patient named above.

I understand there may be a reasonable fee charged for duplication of records and those fees will be provided to me prior to duplication and delivery process.

Please SEND to:
The Institute for Women & Children's Health
29001 Cedar Road Suite 500
Lyndhurst, Ohio 44124
Attn: NURSE

Or please FAX to: 440-442-0501

Patient/POA Signature: _____
Date: _____
Home Phone: _____
Cell: _____