

**THE CLEVELAND CLINIC FOUNDATION
AUTHORIZATION FOR THE RELEASE
OF MEDICAL INFORMATION**

Health Data Services, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

216/444-2640
800/223/2273 ext. 42640
Fax: 216/445-7589

Name: _____ SS#: _____
CCF#: _____ Date of Birth: _____
Telephone #: _____ Current Address: _____
Fax #: _____ Street: _____
Reason for Disclosure: _____ City: _____ State: _____ Zip: _____

(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment: _____
Release Medical Information to: _____

Name of Recipient: **Axiom Requisition Copy Service**

Street: **447 North Canal Road**

City: **Lansing** State: **MI** Zip: **48917**

I hereby authorize The Cleveland Clinic Foundation to release the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes* as defined below. The release of Psychotherapy Notes requires a separate authorization.

*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

Emergency Department Reports	Pathology Reports
Discharge Summary	Laboratory Reports
History & Physical	EMG Reports
EKGs	Operative Reports
Physical/Occupational Therapy Reports	Other (Specify)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire in one year from the date of authorization written below.

I understand that the Recipient of my health information may be charged for the service of releasing medical information.

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____/_____/_____
*Signature of Patient/Legal Guardian*** *Printed Name* *Date Signed*

Relationship if not Patient

***If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney or Death Certificate) MUST accompany the authorization when presented. Exception: parent is signing for patient under age 18.*