Cleveland Clinic

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Patient Information:

Name *(First, Middle, Last)*	Cleveland Clinic Medical Record #
[redacted]	[redacted]
Current Address	City / State / Zip
[redacted]	[redacted]
Last 4 Digits Social Security # / Email	Phone Number / Date of Birth
[redacted] aol.com	[redacted]

2. Release Information From (check all that apply):

☐ Cleveland Clinic Ohio facilities **OR** ☒ Specify Cleveland Clinic Ohio facility(ies): Main Campus -
☐ Cleveland Clinic Nevada facilities **OR** ☐ Cleveland Clinic Akron Physician Offices (PPG)

NOTE: *For release of medical records from Ashtabula County Medical Center (ACMC), Cleveland Clinic Akron General (CCAG), and Cleveland Clinic Florida, your request must be made directly to ACMC, CCAG or Cleveland Clinic Florida*

3. Release Information To:

Name of Recipient The World Journal of Clinical Cases -

Address 7041 Koll Center Parkway, Suite 160, Pleasanton **City/State** Ca, 94566 **Zip** USA

Phone Number: ( ) **Fax Number:** ( )

☐ **Release Information To MyChart Account (large requests over 50 pages will be delivered via alternate option selected below)**
☒ **Paper**
☐ **Secure electronic delivery (provide recipient's email)** _____
Check delivery option desired

Purpose for Disclosure: Publication for Education Purposes
(Purpose for disclosure must be completed prior to processing; e.g. continuing care, personal use, legal)

Dates of Service to Release (FROM): _____ **(TO):** _____

☒ Office Visits	☒ History & Physical	☐ Physical/Occupational Therapy Reports
☐ Emergency Department Reports	☐ Cardiac Reports	☐ Homecare Records
☒ Discharge Summary	☐ Laboratory Reports	☐ Radiation Oncology Records
☒ Operative Reports	☒ Radiology Reports	☐ Other

I, the undersigned, authorize Cleveland Clinic to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

[redacted]

*Signature of Patient/Patient's Personal Representative*** | *Printed Name* | *Date Signed*

_____
Relationship, if not Patient

**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 records.*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*

****For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

Submit request to **one of the following:**

(1) Health Information Management/Medical Record Department.
Health Data Services Ab7
9500 Euclid Avenue, Cleveland, OH 44195

(2) Fax 1-216-587-8043
Questions? 1-216-444-5580

Revised 9/5/19