Crossroad
HEALTH CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please print:

_____ _____
Patient's full name Date of Birth

_____ _____
Patient's street address Phone Number

_____
City, State, Zip Code

Release Records From:
Organization: _____ Phone: _____

Address: _____

The undersigned hereby authorizes release of the following portions of the medical records* of the above named patient.

___ Entire medical record (for the period of _____ to _____)
OR
The following specific portions of the patient's record for the period of _____ to _____
___ The History/Database/problem list
___ Progress notes, including history & physical
___ Medication sheet/medication information
___ Information pertinent to particular illness/condition _____.
___ Lab & diagnostic test results _____.
___ Other _____.

Please release these records to:

_____ **Crossroad Health Center**
5 E. Liberty Street
Cincinnati, OH 45202
Phone:(513) 381-2247/ Fax:(513) 381-2256

_____ **Crossroad Health Center Harrison**
10450 New Haven Rd
Harrison, OH 45030
Phone:(513)367-5888/ Fax:(513)367-1015

_____ **Crossroad Health Center Rothenberg SBHC**
241 E Clifton Ave
Cincinnati, OH 45202
Phone:(513)363-5779/ Fax:(513)363-5781

_____ **Crossroad Health Center West**
2859 Boudinot Ave Suite 107
Cincinnati, OH 45238
Phone: (513)922-4271/Fax: (513)922-3936

_____ **Crossroad Health Center Taft SBHC**
270 Southern Ave
Cincinnati, OH 45219
Phone: (513)363-5624/Fax: (513)363-5622

The medical record is needed for the following purpose:

___ Primary Care ___ Other: _____

(state general purpose or intended use of the medical record)

I understand that I may revoke this release at any time, in writing, but the request shall remain valid until recoked or upon the expiration in sixty (60) days which ever occurs first, except to the extent that action has been taken thereon. This authorization includes the use and/or any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

*This authorization will expire in sixty days or ___ / ___ / _____ by my request.

_____ _____ _____

Signature** (as designed by law) Date Relationship
(if other than patient)

_____

Witness

*If a fee will be charged, kindly contact our office prior to copying.

**Patient-not parent/legal guardian must sign if emancipated minor, or under conditions by law.

Date request sent ___ / ___ / _____

Date records received ___ / ___ / _____