Crossroad Health Center Medical Records Request

Name: _____

Date of Birth: _____ **Phone:** _____

Patient Street Address: _____

City, State, Zip: _____

Please Release Records From:

Organization: [ ] Fax: [ ]

Please send the following records:

[ ]

[ ]

[ ]

Please release these records to:

_____ **Crossroad Health Center**
5 E Liberty St
Cincinnati, OH 45202
P:(513) 381-2247 / F:(513) 381-2256

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

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

___**Crossroad Health Center Taft SBHC**
270 Southern Ave
Cincinnati, OH 45219
P:(513) 363-5624 / F:(513) 363-5622

___**Crossroad Health Center Rothenberg SBHC**
241 E Clifton Ave
Cincinnati, OH 45219
P:(513) 363-5778 / F:(513) 363-5781

The medical record is needed for the following purpose:
____ Primary Care ____ Other:_____
I understand that I may recoke this release at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever 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: ___/___/_____