Authorization for Release and Examination of Medical Records

PLEASE DO NOT LIST MULTIPLE DOCTORS OR HOSPITALS.
One per form. Thank You

RE: Patient Name: _____

Date of Birth: _____

I hereby authorize and request the following doctor and/or hospital:

Doctor: _____

Hospital: _____

Street Address: _____

City, State ZIP: _____

Phone Number: _____ FAX Number: _____

to release any and all of my medical records and information to:

Southwest Family Physicians, Inc.
Affiliated with Southwest General Medical Group, Inc.
7225 Old Oak Blvd., Suite 210A
Middleburg Hts., OH 44130
440-816-2761
440-816-8065 FAX

I hereby authorize and request your office to furnish a complete and accurate copy of my medical information, also known as Protected Health Information ("PHI") and related data for the following time period: Beginning Date: _____ Ending Date: _____ or **Any and All Dates** you may have on file. I am aware that there may be information in my medical record that relates to substance abuse, mental illness or HIV/Aids that is of a highly confidential level.

I am aware that I can revoke this Release at any time prior to the records being released to the above-named Southwest Family Physicians, Inc. and this Release is valid for a limited time of 90 days.

X_____ _____
Patient Signature / Legal Guardian Date