Authorization for Release of Medical Records

Southwest Family Physicians, Inc.
Affiliated with Southwest General Medical Group
7225 Old Oak Boulevard, Suite 210A
Middleburg Heights, Ohio 44130
440-816-2761 / 440-816-8065 FAX

RE: Patient Name: _____

Date of Birth: _____

I hereby authorize and request Southwest Family Physicians, Inc. ("SWFP") 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.

SEND TO:

Recipient: _____

Address: _____

City, State Zip:_____

Phone/FAX: _____

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

I am also aware that I may be charged the following fees as defined by Ohio Revised Code 3701.74:

If the request is made by the patient or the patient's personal representative

$3.35 per page for the first ten pages	70 cents per page for pages 11 - 50	28 cents per page for pages 51 and higher	Cost of postage for mailing

If a person other than the patient or the patient's personal representative makes the request. An initial fee of twenty dollars and and six cents ($20.06), which shall compensate for the records search

$1.36 per page for the first ten pages	70 cents per page for pages 11 - 50	28 cents per page for pages 51 and higher	Cost of postage for mailing

X_____ _____

Patient Signature / Legal Guardian Date