

Gahanna Family Practice, Inc.

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Authorization for Release and Examination of Medical Records (PHI)

Patient's Name: _____ **Date of Birth:** _____

**** Mail or deliver completed form with original (not photocopied) signature to Gahanna Family Practice. ****

I hereby authorize **Gahanna Family Practice, Inc.** to furnish the following medical information, also known as Protected Health Information, and related data for the above named person.

- Complete Records _____
- Specific Office Notes (Date Needed: _____) _____
- Specific Tests _____
- X-Rays _____

Records to be released to: _____

Reason for Request: _____

I am aware that there may be information in this 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 entity and that this record request is valid for a limited time of 60 days.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further redisclosure is strictly prohibited.

I am also aware that, effective January 1, 2005, there will be a per-page charge assessed before records can be forwarded. (See our website for medical records fee schedule: www.gahannaFP.com/records)

Signature of Patient or Legal Guardian: _____ **Date:** ___ / ___ / ___

Printed Name of Legal Guardian: _____

For office use: Records reviewed by: _____ Date: ___ / ___ / ___

Records sent by: _____ Date: ___ / ___ / ___