# Grace Hospital

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, hereby authorize Grace Hospital and its employees and agents to release the following information from the medical records of:

Patient Name: ______________________________________________
Last (Include Maiden Name) First Middle

Date of Birth: ______________________ Social Security #: ______________________

Address: ______________________________

______________________________

______________________________

______________________________________________

Treatment Dates: ______________________________________________

**Information To Be Disclosed:**

☐ Discharge Summary ☐ History & Physical ☐ Consultation Reports

☐ Operative Report ☐ Laboratory Reports ☐ Radiology Reports

☐ Radiology Films ☐ Pathology Reports ☐ Entire Record

☐ Other: ______________________________________________

**Please Release Information To:**

Name of Person/Organization: ______________________________________________

Address: ______________________________________________

Phone #: (     ) ______________________________________________

Purpose of Disclosure: ______________________________________________

I understand and acknowledge that the medical records to be released may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that the personal health information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. **Federal Regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.**

I understand that Grace Hospital may not condition treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization form, except:

a. When acting as a covered health care provider, Grace Hospital may condition the provision of research-related treatment on the signing of this authorization form for use and disclosure of protected health information for such research.

b. Grace Hospital may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on signing of this authorization to allow for the disclosure of such protected health information to such third party.

I understand that this authorization is valid for 60 days from the date of signature, unless revoked by written notice to Grace Hospital as described in its Notice of Privacy Practices providing said notice is received prior to release of the information.

As a professional courtesy, I understand that no cost will be assessed for information released directly to my health care provider. I understand that all other releases are subject to copy and distribution costs. Specifically, I understand there may be charges for the retrieval, copying and release of medical information and accept financial responsibility.

Grace Hospital, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

X ________________________________________ ______/______/______
Signature of Patient/Legal Representative Date Signed

________________________________________ ☐ Patient Unable to sign
Relationship to Patient

X________________________________________ ______/______/______
Signature of Witness Date Signed

X________________________________________ ______/______/______
Signature of Witness Date Signed

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**NOTICE**

- A copy of legal documents MUST accompany the authorization if presented by the patient's legal representative.
- An incomplete or improper authorization will not be honored.
- If you have any questions call the Health Information Management Department at (216) 476-2822.

## Mailing Address:

Grace Hospital – 6 North
Attn: Health Information Management
C/O Fairview Hospital
18101 Lorain Avenue
Cleveland, Ohio 44111


Grace Hospital

Cleveland Clinic affiliate
2307 West 14th Street
Cleveland, Ohio 44113-3698


Authorization For Release of Medical Information MR-100 Rev. 05/07


**Grace Fairview**
18101 Lorain Avenue
Cleveland, Ohio 44111
Phone: 216-476-2704
Fax: 216-476-2706

**Grace Amherst**
254 Cleveland Avenue
Amherst, Ohio 44001
Phone: 440-988-6141
Fax: 440-988-6148

**Grace Huron**
13951 Terrace Road
Cleveland, Ohio 44112
Phone: 216-761-2900
Fax: 216-761-2911

**Grace Lakewood**
14519 Detroit Avenue
Lakewood, OH 44107
Phone: 216-529-7186
Fax: 216-227-2653