AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION
Requesting Records

Copying Fee: $20

Print Name: _____ DOB:_____

I, _____, authorize Trumbull-Mahoning Medical Group to use and/or disclose my health information as identified below to:

□ Self (Requesting the records for yourself, place your address).
OR Name and address of the person you wish to receive the records.

□ Name:

Address:

For purpose of:

□ The request of the individual □ Further medical treatment

□ Insurance □ Other

Please choose the method of Delivery: □ U.S. Mail (To above address)

□ I will pick up the records personally. (You will be called when ready).

By checking the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ Laboratory and Pathology Reports

_____ Most recent two year history, **this is what is most commonly copied** ($20)

_____ The entire medical record. (To copy the entire medical record there will be an additional fee according to the number of pages copied.)

_____ Diagnostic Imaging Reports

_____ Billing Statements

_____Specific Dates of Service

***** The following items must be checked to be included in the use or disclosure of other health information:

_____ *HIV/AIDS related health information and/or records

_____ *Mental health information and/or records

_____ *Genetic testing information and/or records

_____ *Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Trumbull Mahoning Medical Group.

Unless revoked earlier, this authorization will expire 60 days from the date of signing.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand there will be a charge of $20 for copying the medical record as describe on the previous page. (To copy the entire medical record there will be an additional fee).

Signature of Individual or Individual's Legal Representative		Date

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)

PLEASE SUBMIT THIS FORM BY MAIL OR TAKE TO THE OFFICE WHERE YOU WERE SEEN BY YOUR DOCTOR WITH A PAYMENT OF $20.
(IF YOU ARE REQUESTING THE ENTIRE CHART THERE WILL BE AN ADDITIONAL FEE FOR EACH ADDITIONAL PAGE COPIED).

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