Richard R Hill MD PhD

Authorization for the Exchange of Protected Health Information

Patient Name:_____ Address:_____
City:_____ State:_____ Zip:_____
DOB: _____ SSN (last 4): __ __ __ __ Phone: (____) _____

Info to be released FROM:

Richard R Hill MD PhD
19910 Malvern Road, Suite 223
Shaker Heights, Ohio 44122
Ph: 216-309-1550
Fax: 864-383-0849

Info to be released TO:

Name _____
Address _____
_____
Phone# _____
Fax # _____

Info to be released FROM: ___

Name _____
Address _____
_____
Phone # _____
Fax # _____

Info to be released TO:

Richard R Hill MD PhD
19910 Malvern Road, Suite 223
Shaker Heights, Ohio 44122
Ph: 216-309-1550
Fax: 864-383-0849

Scope and Use of Disclosure (Information to be released):
___ Last Visit Notes ___ Notes from:_____ to: _____ (only)
___ Complete Chart ___ Lab Results ___ Other:

Purpose of Disclosure:
___ New Provider ___ Legal ___ Insurance ___ Disability ___ Personal Use
___ Follow up/referral ___ Continuity of Care ___ Other:

I hereby authorize Richard R Hill MD PhD Inc and its office staff the right to exchange any and all information contained in my medical records with the individual/entity indicated above. I understand and acknowledge that this may contain all information checked above. If "complete chart" is checked, this may include physical and mental illness, alcohol/drug abuse history or HIV/AIDS test results, diagnosis and/or treatment. I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to re-disclosure by the recipient. I understand that authorizing the disclosure of this health information is voluntary and that my treatment will not be based on

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whether or not I sign this authorization. Access to medical information is the right of every patient, however, I understand that I may be charged for copies according to the Ohio revised codes 3701.74, 3701.741 and 3701.742

I understand that I am signing this authorization to ensure proper/necessary healthcare

This permission will expire one year from date signed unless otherwise indicated

_____	_____	___/___/___
Patient Signature/Personal Rep	Printed Name	Date
_____	_____	___/___/___
Relationship, If not patient	Printed Name	Date