Richard R Hill MD PhD

AUTHORIZATION FOR THE EXCHANGE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Address: _____

City: _____ State: _____ Zip:_____DOB: _____

SSN (last 4 digits) __ __ __ __ Phone#:(_____)_____

Information to be Released FROM:

Richard R Hill MD PhD
29425 Chagrin Blvd, Suite 301
Pepper Pike, OH 44122
Office: 216-292-1610
Fax: 216-292-1627

To be Released TO:

Name_____
Address_____
_____
Phone #_____
Fax #_____

Information to be Released FROM:

Name_____
Address_____
_____
Phone# _____
Fax#_____

To Be Released TO:

Richard R Hill MD PhD
29425 Chagrin Blvd, Suite 301
Pepper Pike, OH 44122
Office: 216-292-0610
Fax: 216-292-0627

B. Scope and Use of Disclosure: (Information to be released)

_____ Last Visit Notes _____Notes From: _____ to: _____(only)

_____ Consult Reports _____ Complete Chart _____ Lab results _____Other_____

C. Purpose of Disclosure: (Reason for 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 all physical and mental illness, alcohol/drug abuse history or HIV/AIDS test results, diagnosis and/or treatment.***

OVER——->

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. I understand that my treatment will not be based on 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 form will expire <u>one year</u> from date signed unless otherwise stated

_____	_____	____/____/____
Patient's signature /Personal Representative	*Printed Name*	*Date Signed*
_____	_____	____/____/____
Relationship, if not Patient	*Printed Name*	*Date Signed*