AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Print Patient's Name_____ Date_____

Dr. James McMahan, MD
4845 Knightsbridge Blvd. #230
Columbus, OH 43214
(614) 459-0060 FAX (614) 459-0110

I AUTHORIZE YOU TO RELEASE RECORDS TO:

To:_____
(Name of Institution Holding Records)

Address:_____

City: _____ State: _____ Zip: _____

FOR THE PURPOSE OF: _____
(Reason for Releasing Information)

Release the following portion(s) of patient's medical record during the time period of_____

___Discharge Summary	___Physician's Orders	___ECG Report
___Nurse's Notes	___X-Ray Report	Other_____
___Entire Medical Record	___Pathology Report	_____
___Lab Report	___Progress Notes	_____
___Operative Record	___History & Physical Report	_____

This authorization will remain in effect for six months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by patient at any time, but it is not retroactive to release of information made in good faith.

By signing this authorization, the undersigned agrees NOT to disclose or make copies of indicated information, unless further disclosure is expressly permitted by necessary implication inherent in the purposes of the original consent or authorization.

Proposed new use of information without additional written consent of the person to whom it pertains is prohibited.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that if there is a charge for copies, that such charges must be paid prior to release of copies.

_____ Signed_____
(Patient/Responsible Party) Signature of Witness

Address_____

City_____

State_____ Zip _____ Patient's Birthdate: _____