DOXOLOGY
HEALTH & FERTILITY

1197 High St, Suite 102
Wadsworth, OH 44281
Phone: 330.529.9229
Fax: 330.529.9211

Medical Record Request

Patient Name: _____ SSN: _____

Address: _____

Date of Birth: _____ Phone #: _____

I authorize the following party to release my medical records :

_____
_____
_____

Release Information To: Doxology Health and Fertility
1197 High St, Suite 102
Wadsworth, OH 44281
Phone: (330) 529-9229
Fax: (330) 529-9211

My authorization extends to the following:

_____ All records
_____ Progress notes
_____ Mammogram/Bone density
_____ Lab/Pathology reports
_____ Xray/Sonogram Reports
_____ Immunizations
_____ Other (please specify) _____

The information will be used or disclosed for the following purpose:

____ Continued Care _____ Personal Use _____ Second opinion _____ Transfer of care
____ Insurance Claim/Application _____Attorney/Legal

This authorization is given voluntarily with the understanding that:

1. My treatment will not be impacted by signing this authorization.
2. The information in my health record may including information related to sexually transmitted disease, HIV/AIDS, mental health services, and treatment for alcohol and drug abuse.
3. I will receive a copy of this authorization upon signature.
4. I have the right to revoke consent of disclosure in writing up to and until the records are received by Doxology Health and Fertility.
5. This consent is valid for 30 days from the date of signature.
6. Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws and could be re-disclosed by the person(s) receiving it. I hereby release Doxology Health and Fertility from any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature: _____ Date: _____

Name (print): _____

Guardian/Authority of Representative is Signing for the Individual _____