Authorization for Release of Medical Records

I, the undersigned, hereby authorize Fairlawn Family Practice to receive medical records on the patient below. Please mail records to:

50 N. Miller Road
Akron, Ohio 44333
Phone: 330-836-9721
Fax: 330-836-9627

J. Joseph Payton, DO
Marcie A. Groesbeck, MD
Douglas Lefton, MD
Edward J. Parisi, MD

Receive Medical Records From:

Full Facility/Doctor Name____

Address: ____

Phone: ____

Receive Medical Records From:

__ Entire Record

__ Emergency Room Report

__ Medication List

__ Consultation Reports

__ Pathology/Lab Reports

__ Radiology Reports

__ EKG/Cardiac Testing Reports

__ Other

Dates of Service/Treatment needed (If Applicable):

I understand and acknowledge that the medical records may contain information regarding psychiatric disorders, human immune virus (HIV) test results, acquired immune deficiency syndrome (AIDS), AIDS-related conditions, alcohol and/or other dependency abuse.

Patient Signature: ____

Date: ____

Patient Executor: ____

Date: ____

(A copy of this release shall have the same authority as the original)

Patient's Name: ____

Birthdate: ____

Address: ____

SS Number: ____