

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
Adrienne Hester, MD
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: _____