E.C.O HEALTH CENTER 1587 KINNEY AVE CINCINNATI, OHIO 45231/ 513-635-2616/ FAX 513-672-2043

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____, hereby authorize

E.C.O Health Care Center Inc., 1587 Kinney Ave Cincinnati, Ohio 45231

To disclose the following specific medical information by ___mail or ____fax TO: 513-672-2043

INFO OF OFFICE THAT WILL BE RECEIVING YOUR RECORDS

Name: _____

Address: _____

City, St., Zip: _____

Office Telephone: _____ Fax: _____

From the Health Records of:

PATIENT'S INFORMATION

Name: _____DOB_____Last 4 of SS#_____

Address:

_____

City, St., Zip:

_____

For the purpose of:

_____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments _____ Records of visits (all visits)

_____ Progress Notes _____ Photographs, videotapes, digital or other images

_____ Discharge summary _____History and Physical Examination

_____ Consultation Reports

_____ Record of visit for specific date or dates specific dates include or are limited to:

_____

_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)

_____ All of the above

_____ other (Must be specific) _____ Mental Health and/or alcohol and drug abuse treatment _____ Hepatitis information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except

as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.

4. North Country Family Practice, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Patient's Name Printed Date _____
_____ Patient's signature (or guardian, if a minor) Expiration date (if other than one year from date above)

_____
_____ Social Security Number (for identification purposes only)
Date of Birth _____
_____ Patient's Personal Representative Date Patient's Personal Representative's Authorization to Act