Jeffrey S. Masin, MD

300 Locust Street, Suite 100
Akron, Ohio 44302
330-379-9070
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Record Release

Patient's Name: ____________________________________ Date of Birth: __________________

Previous Name: ____________________________________

I request and hereby authorize Jeffrey S. Masin, M.D. to release health care information of the patient named above to:

Name: ____

Address: ____

City, State: _______________________________________ Zip Code: ____________________

This request and authorization applies to:

- ❏ Only health care information relating to the following treatment, condition, or dates of treatment: ____
- ❏ All health care information
- ❏ Other: ____

This information will be disclosed for the following purposes:

- ❏ At the patient's (or parent/guardian) request
- ❏ ____

This authorization expires on: ______________________________ (cannot exceed 6 months)

I understand that I may revoke this authorization in writing at any time except to the extent that the office of Jeffrey S. Masin, M.D. has already released information after I gave this authorization. I may revoke this authorization by writing a letter to the office of Jeffrey S. Masin, M.D. and giving the name or other specific identification of the person(s) that I no longer want to receive information.

I also understand that I do not have to sign this authorization to receive treatment.

Once the office of Jeffrey S. Masin, M.D. gives out the information that I want released, I know that Jeffrey S. Masin, M.D. has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

____ ____________________

Signature of patient or patient's authorized representative — Date signed

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Relationship of signed by anyone other than the patient