Jeffrey S.
Masin, MD

MEDICAL RECORDS RELEASE

Name: _____ Date of Birth: _____
Phone: _____ SS#: _____
Release to: _____
Release from: _____

GENERAL AUTHORIZATION:

I hereby authorize my medical records be released to/from Jeffrey Masin, M.D., 3085 W. Market St., Fairlawn Ohio, 44333. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed.

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 request

☐ _____

This authorization ends:

☐ on _____ (no longer than one year from date signed).

☐ When the following event occurs _____.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. A copy of this authorization may be utilized with the same effectiveness as an original.

Once the above entity gives out the information that I want released, I know that they have 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 Date

_____ _____
Witness Signature of Legal Guardian/Executor Date

Records Released by: _____

Date: _____ Records: ☐ Picked up ☐ Mailed ☐ Faxed

Jeffrey Masin, MD

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