Beckett Ridge
FAMILY MEDICINE

Authorization for Release of Medical Records

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____

Last 4 Digits of Soc. Sec. #: _____ Maiden Name (if applicable): _____

I hereby request and authorize: _____
(Facility Name)

Address: _____

Phone: _____ Fax: _____

To release medical information about the above named patient to: Beckett Ridge Family Medicine

Information to be released for continuation of medical care (choose one):

○ All medical records* – send only the first two (2) years initially, additional dates will be requested when necessary.

○ Only medical records related to a specific treatment and/or date(s) of service.
List treatment and/or applicable date(s): _____

Format to receive records (check one): □ CD ☒ Paper **(Do not fax more than 20 pages)**

The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization can be cancelled, in writing, at any time. I understand that a cancellation will not apply to information that has already been released under this authorization. I understand that the medical records to be disclosed may include information relating to treatment, diagnosis, or testing of drug and/or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS), and/or testing for antibodies to the AIDS virus (HIV).

Unless otherwise indicated, this authorization will expire one (1) year from the date of signature.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

4870 Wunnenberg Way West Chester, Ohio 45069
Phone: 513.860.4600 Fax: 513.860.9059