Fairfield INTERNAL Medicine, Inc.

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

TO: DOCTOR/HOSPITAL _____

Address: _____

_____

City: _____ **State & Zip** _____

Phone: _____ **Fax:** _____

AUTHORIZATION FOR FAIRFIELD INTERNAL MEDICINE TO RECEIVE RECORDS:

I hereby authorize Fairfield Internal Medicine, Inc. to receive a copy of my medical records pertaining to Medical History, Mental or Physical Condition, Services Rendered or Treatment. Please send the records to:

FAIRFIELD INTERNAL MEDICINE, INC.
135 N. Ewing St., Suite 305, Lancaster, OH 43130-3379
Phone 740-681-9447 • Fax 740-681-9966

☐Dr. John Abidin ☐Dr. Michael Murray ☐Dr. Christopher Nickison

Patient Name: _____ **Date of Birth** _____

Social Security# _____ **Phone #** _____

INFORMATION REQUESTED: ☐LAST THREE (3) OFFICE NOTES ☐LABS

☐ALL PERTINENT MEDICAL RECORDS ☐RADIOLOGY ☐OTHER _____

DURATION:

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire 60 days from the date of signature and will only be valid for the records dated prior to the date of signature.

RESTRICTIONS/REQUIREMENTS:

Any disclosure of medical information by the receipient(s) is prohibited by law except when implicit in the purposes of this diclosure or unless a valid authorization is obtained.

Patient Signature: _____ **Date:** _____

Representative's Signature: _____ **Date:** _____

RELATIONSHIP TO PATIENT:

☐Legal Guardian ☐POA ☐Parent ☐Executor of Estate ☐Other _____