Authorization to Release Medical Information To InteCare Medical Clinic

Patient Name (First, Middle, Last)	Date of Birth: --.-.J --.-.J	Last 4 digits of Patient's Social Security Number:	Telephone Number: ( )

Dates of Service to Release (From): (To):

Specific Reports to be Disclosed:

O Chronic Diagnoses
O Medical Marijuana
O Laboratory Reports
O Treatment and progress
O HIV Dx and Rx
O Complimentary Tx
O Substance Use Disorder
O Treatment Plan
O Response to Tx
O Consults
O Mental Health Dx and Rx
O Other: _____

Purpose of Disclosure: O Medical Treatment O Consult O Change Care

Release Information To:

O InteCare Medical Clinic

Release Information From: (specify recipient and complete address)	**Release Information To:**
(Name)	InteCare Medical Clinic — InteCareMedicalClinic.com
(Address)	530 E Dayton Yellow Springs Rd — Ph: 937 874 5766
	Fairborn, OH 45324 — Fax: 937 874 5774
(Phone) (Fax)	

Per Ohio Revised Code 3701.74[1], **you may be charged a fee for print or USB copies of medical records.**

I hereby authorize the treatment facility Indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol orl substance use disorder, AIDS (Acquired Immunodeficiency Syndrome), and may include results of an HIV test or the fact that an HIV test was performed. Information in the form of audio, photo or video.
I expressly consent to the release of information designated above.

This authorization is valid for **365** days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. ***The revocation of this authorization is effective except as indicated in The Ohio State University Health System's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA.***
I understand that InteCare Medical Clinic cannot condition my treatment or payment for health care on this Authorization

I understand that my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse patient records, and this notice accompanies a disclosure of such information. This information has being disclosed to from records protected by Federal Confidentiality Rules. The Federal Rules prohibit the making any further disclosure of this Information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

A general authorization for the release of medical or other Information is not sufficient for this purpose. The Federal Rules restrict any use of information To criminally investigate or prosecute any alcohol or drug abuse client.

Signature of the Patient or Person Authorized to Consent — Date Signed

Relationship if not the Patient

Witness (optional) — Date Signed

InteCare Medcal Clinic
530 E Dayton Yellow Springs Rd
Fairborn,Ohio 45324-6432
Phone: (937) 874-5766
Fax: (937) 874 5774
InteCareMedicalClinic.com