1. PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	OTHER NAMES

CURRENT ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH (mm/dd/yyyy)	PHONE NUMBER

2. INFORMATION NEEDED/PURPOSE

INFORMATION TO BE DISCLOSED FROM (check as applicable):

☐ **SUMMA HEALTH SYSTEM AKRON CAMPUS**
Medical Records / ROI
525 East Market Street, Akron, OH 44309
releases@summahealth.org

☐ **SUMMA HEALTH SYSTEM BARBERTON CAMPUS or WADSWORTH-RITTMAN MEDICAL CENTER**
Medical Records / ROI
155 Fifth Street NE, Barberton, OH 44203

☐ **SUMMA HEALTH MEDICAL GROUP**
1077 Gorge Blvd., Akron, OH 44310
healthport@summahealth.org

☐ **MEDINA AMBULATORY SURGERY CENTER**
3780 Medina Road, Suite 120, Medina, OH 44256

INFORMATION TO BE DISCLOSED (check as many as applicable):

Pertinent Summary (includes all * items below)

- *Discharge Summary
- *Emergency Room Report
- *History & Physical
- *Consultation Record
- *Operative Report
- *Pathology Report
- *Cardiac Cath Report
- *Radiology Reports
- *Lab Reports
- *EKG Report
- HIV/AIDS Test Results
- Medications
- Nurses Notes
- Entire Record
- Other: _____

Behavioral Health/Substance Use Disorder (SUD) Records

- All inpatient behavioral health and SUD records except for psychotherapy notes and SUD counseling notes
- Only those behavioral health and SUD records listed below:
  - Diagnostic
  - Drug test results
  - Medications
  - Mental health
  - addiction assessment
  - Clinical notes

Requesting the following dates of service: _____

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

☐ Personal
☐ Workers' Compensation
☐ Legal
☐ Other (please specify):_____

3. ACTIONS TO TAKE

RELEASE INFORMATION TO:

NAME OF RECIPIENT: _____

ADDRESS: _____ CITY/STATE: _____

ZIP: _____ PHONE NUMBER: _____

EMAIL: _____

INFORMATION SHOULD BE DELIVERED AS FOLLOWS (select one):

☐ Release to MyChart
☐ Compact Disc (CD)
☐ Flash drive
☐ Paper
☐ Email

To release directly to physician's office, please provide recipient information above.

****CONTINUED ON THE BACK PAGE WHERE YOUR SIGNATURE IS REQUIRED****

PATIENT LABEL

Summa Health™

Summa Health System

PTR-25-74443/CS/RH/03-25

SRELOFPHI

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, the undersigned, authorize Summa Health to release health information as indicated on page 1 of this document.

I understand:

- The requested health information could contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug use.
- Except for substance use disorder (SUD) records as described below, Summa Health will not condition treatment, payment, enrollment in the health plan or eligibility for benefits on whether I sign this Authorization, except (1) for research-related treatment, or (2) if the purpose of the healthcare is to create information for disclosure (such as an employment physical or independent medical exam).
- After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law.
- I have the right to revoke this Authorization anytime by submitting a written revocation SUMMA HEALTH SYSTEM AKRON CAMPUS Medical Records / ROI 525 East Market Street Akron, OH 44309, except to the extent information has already been released in reliance on this Authorization.
- This Authorization will expire one year from the date written below, unless revoked by me (or my personal representative) through written notice presented to SUMMA HEALTH SYSTEM AKRON CAMPUS Medical Records/ ROI 525 East Market Street Akron, OH 44309.
- The recipient of my health information may be charged for the service of releasing medical information as permitted under state and federal law as applicable. There is no charge to send records directly to my health provider for continuing care purposes.

For **SUD records** protected under 42 C.F.R Part 2, in addition to the above, I understand:

- My SUD records (or information contained in the records) may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.
- There is potential for my SUD records to be redisclosed by the recipient and no longer protected by Part 2.
- I may be denied services if I refuse to consent to use or disclosure for treatment, payment or health care operations, if permitted by law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

If the Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

Signature of Patient/Patient's Personal Representative*	Printed Name	Date

Relationship, if not Patient

*If other than the patient's signature, a copy of legal paperwork verifying patient's personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). For a deceased patient, a person with legal authority to act on behalf of the deceased individual or individual's estate. For minors, the person authorized to give consent.

Submit completed authorization to the address or email address of the facility from which you are requesting records (see page 1). If requesting records from more than one facility, please send a separate form to each facility.