DR. JAMES E. PHILLILPS
600 PORTAGE TRAIL
SUITE D
CUYAHOGA FALLS, OHIO 44221
(330)376-4445

RELEASE OF MEDICAL RECORDS

PATIENT'S NAME:____

DATE OF BIRTH:____

PREVIOUS PHYSICIAN NAME:____

ADDRESS:____
(INCLUDE CITY, STATE, & ZIP CODE)

PHONE NUMBER:______________________________FAX NUMBER___________________________

I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS, TREATMENTS, AND EXAMINATIONS RENDERED TO ME. I UNDERSTAND AND ACKNOWLEDGE THAT MY MEDICAL RECORDS MAY CONTAIN ALCOHOL, DRUG , HIV, OR MENTAL HEALTH INFORMATION. ALL MEDICAL RECORDS/INFORMATION SHOULD BE SENT TO:

***DR. JAMES E. PHILLIPS, 600 PORTAGE TRAIL, SUITE D, CUYAGOFA FALLS, OH 44221-3055

_____DOCTOR'S PROGRESS NOTES, BLOOD WORK, XRAY/EKG'S – LAST 2 YEARS

_____MEDICATION LIST – LAST 2 YEARS

_____HOSPITAL IN-PATIENT RECORDS – LAST 2 YEARS

_____OUTPATIENT DIAGNOSTIC TESTS/INPATIENT DIAGNOSTIC TESTS – LAST 2 YEARS

PATIENT SIGNATURE:____

DATE:____

WITNESS:____

THIS AUTHORIZATION SHALL BE VALID UNTIL____

****A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL****