STARK MEDICAL SPECIALTIES, INC.

2458 Lincoln Way East, Massillon, OH 44646 Phone: (330) 837-1111 Fax: (330) 832-1341

Authorization For Release of Protected Health Information

I,_____, _____/_____/_____, _____/_____/_____ authorize
(print patient's name) (birthdate) (Social Security No.)
Stark Medical Specialties, Inc. to release my information

TO: (Facility Name) _____ From: (Facility Name) _____

Street Address _____ _____

City, State, Zip) _____ _____

MAIL _____ FAX #: _____ PICK UP ON _____

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PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

_____ 1. I authorize all information in my medical record from (date) _____ to (date)_____ to be disclosed according to the terms of this Authorization.

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INITIAL ONE OF THE FOLLOWING:

_____ I consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

_____ I do not consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any Condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

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FOR THE PURPOSE OF:

_____ Continued Care: _____Personal Use Other:_____

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1. This authorization shall be in full force and effect for (60) sixty days from the date of the signing, at which time this authorization shall expire.
2. My permission is extended only for the purpose as stated on this authorization and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Stark Medical Specialties, Inc. at 323 Marion Avenue NW, Massillon, OH 44646. I understand that a revocation is not effective to the extent that Stark Medical Specialties has relied on the use or disclosure of the protected health information.
3. I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _____ (initial)
4. I understand that information used or disclosed pursuant to the authorization my be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If Stark Medical Specialties is receiving the information, Stark Medical Specialties will only use or disclose the information as permitted by law or as authorized by you.
5. Stark Medical Specialties will not condition my treatment on whether I provide authorization for the requested use or disclosure.
6. I understand I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under law.

_____ _____
(signature of patient or guardian) (relationship to patient) (date)

_____ _____
(address) (home phone number)

_____ _____
(city, state, zip) (work phone number)