www.heartofohiofamilyhealthcenter.org

Capital Park Family Health Center 2365 Innis Road Columbus, OH 43224 614-416-4325



Whitehall Family Health Center 882 S. Hamilton Rd. Columbus, OH 43213 614-235-5555

_Date: ___

RELEASE OF INFORMATION (ROI)

PERSONAL INFORMATION		
Last Name:	First Name:	M.I
Previous Name:	DOB:	Social Security #:
RELEASE OF RECORDS FROM (WHO HAS YOUR RECORDS?)		
Name of clinic or organization:		
Address:	City:	
State:Zip:	Phone #:	Fax #:
RELEASE OF RECORDS TO (WHO NEEDS YOUR RECORDS?)		
Name of clinic or organization:		
State:Zip:	Phone #:	Fax #:
THESE ARE THE RECORDS I WOULD LIKE TO RELEASE (CHECK ALL THAT APPLY)		
☐ Discharge Summary ☐ Counselor's Discharge Summary ☐ History and Physical Exams ☐ Consultation Reports ☐ Outpatient Clinic Notes If you would like to release all records che	-	 ☐ EKG/ECHO Reports ☐ Emergency/Urgent Care Reports ☐ Psychological Tests ☐ For MD only Pathology Slides ☐ Other
For condition or dates of treatment:		
REASON FOR RELEASE		
Continued care by another provider Social Security disability	☐ Insurance claim ☐ Attorney review	Personal Use Other
PATIENT ACKNOWLEDGEMENT		
chemical dependency, sickle released, I will place a check If I change my mind, I may w not apply to records that hav This form expires one year af The time period noted here r There may be a fee for release once the records are release party. At that point, the records	e cell anemia, genetic conditions and AIDS mark here I do not want the followite to the address listed in the header of the already been released. Iter I sign it or sooner (Specify here:	ds cannot prevent them from being released to a third d federal privacy laws.
Patient/Guardian Signature:		Date:

Staff Signature: