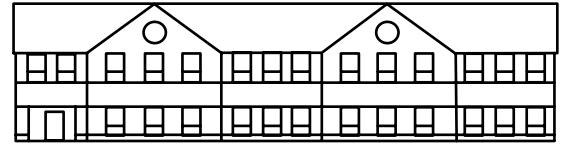


**Family Physicians of Gahanna, Inc.**  
535 Offcenter Pl. • Gahanna, Ohio 43230  
(614) 471-9654 • fax (614) 471-9634  
www.fpoginc.com • info@fpoginc.com



## Authorization for Release and Examination of Medical Records (PHI)

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**\*\* Completed form should be sent to the provider you are requesting records from. \*\***

I hereby authorize \_\_\_\_\_ to furnish the following  
Name and Address of Physician's Office  
medical information, also known as Protected Health Information, and related data for the above named person.

- Complete Records \_\_\_\_\_
- Specific Office Notes (Date Needed: \_\_\_\_\_ ) \_\_\_\_\_
- Specific Tests \_\_\_\_\_
- X-Rays \_\_\_\_\_

**Records to be transferred to: Family Physicians of Gahanna, Inc.  
535 Offcenter Place  
Gahanna, OH 43230-5316**

**Reason for Request:** \_\_\_\_\_

I am aware that there may be information in this medical record that relates to:

**Substance Abuse, Mental Illness, or HIV/AIDS that is of a highly confidential level.**

I am aware that I can revoke this release at any time prior to the records being released to the above named entity and that this record request is valid for a limited time of 60 days.

**PROHIBITION OF REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by law. Any further redisclosure is strictly prohibited.

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Printed Name of Legal Guardian:** \_\_\_\_\_

**For office use:**

Records received by: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_