

WORTHINGTON FAMILY PYSICIANS INC.  
874 PROPRIETORS RD  
WORTHINGTON, OH 43085  
TELEPHONE (614) 885-9405

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, born on \_\_\_\_/\_\_\_\_/\_\_\_\_, hereby  
last name first name middle initial mo. day year

authorize \_\_\_\_\_  
\_\_\_\_\_

to release and furnish to: Dale A. Michalak, M.D. or  
Glenn R. Williams Jr., M.D. or  
Elizabeth Unk, M.D.

The following medical information contained in the medical record regarding my hospitalization, care and/or treatment on the following dates: \_\_\_\_\_ to \_\_\_\_\_  
as an \_\_\_ Inpatient \_\_\_ Outpatient \_\_\_ Emergency Room patient.

Please list specific medical record reports to be disclosed:

\_\_\_\_\_  
\_\_\_\_\_

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, and/or alcohol/durg abuse. I expressly consent to the release of information as designated above.\*

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or person Authorized to Consent

X \_\_\_\_\_  
Relationship, if not Patient

X \_\_\_\_\_ Date \_\_\_\_\_  
Witness

\* If drug and/or alcohol abuse information has been disclosed, these records are protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (Signer to initial for authentication of informed consent.) \_\_\_\_\_