AUTHORIZATION TO RELEASE MEDICAL RECORDS

Constantine V Economous M.D., LLC
2370 Southeast Blvd.
Salem, Ohio 44460
PH:(330) 332-9961 Fax:(330) 337-3282

PATIENT'S NAME:_____DATE OF BIRTH:_____

Patient is requesting and authorizing the disclosure of confidential healthcare information.

Please print name, address and phone number from whom the records are being requested.

FROM: _____TO: Constantine V Economous M.D.
2370 Southeast Blvd
_____ Salem, Oh 44460
Ph:(330)332-9961 FX:(330)337-3282
_____ **DO NOT FAX MORE THAN 20 PAGES**

I would like my records released for the following reason(s)_____

_____ Complete Records
_____ Records of care from _____to_____only

Note: If these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

AUTHORIZATION EXPIRES 1 YEAR FROM DATE OF SIGNATURE

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:

_____DATE:_____