Canton Women's Center
6659 Frank Ave NW North Canton, OH 44720
Phone: 330-966-9090 FAX: 330-966-9030

Authorization for Release of Protected Health Information on PDF file on a USB flash drive portable data storage device

I,_____,_____/_____/_____, _____/_____/_____,
(Patient Name) (Date of Birth) (Social Security Number)

(____) _____-_____, _____
(Phone Number) (Address)

I Authorize the Canton Women's Center to release my medical records with protected health information in PDF format transferred into a portable USB flash drive data storage device.

PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

I authorize the following individually identifiable health information to be disclosed:

☐ Entire medical record
[ ] Pertinent Summary
Last 3 years
[ ] Test Results _____
[ ] Other _____

INFORMATION WILL BE USED/DISCLOSED FOR THE FOLLOWING PURPOSE:

XXX Continued Treatment XXX Personal Use _____ Other _____

I understand and authorize that my medical record may contain alcohol/drug and or Human Immune Virus, Acquired Immune Deficiency Syndrome and/or mental health information and I expressly consent to the release of any such information contained in the records designated above. I also understand that I will be responsible for any charges incurred for the transfer of the data to the USB drive.

This information has been disclosed to me from confidential records protected from disclosure by State/Federal Law. I shall make no further disclosure of this information without the specific written and informed release of the individual to whom it pertains, or as otherwise permitted by State/Federal Law. It is my responsibility to safeguard my medical records contained in the provided USB drive.

This authorization for release of information is valid for 60 days from the date of signature, unless revoked in by written notice to the providing facility, providing said notice is received prior to release of information.

_____ _____
Printed Patient Name Date

_____ _____
Signature of Patient or Authorized Representative Relationship to Patient

_____ I have received from the Canton Women's Center a USB flash drive containing all my available electronic medical records (2012 to present) on a PDF file. I am responsible for the safekeeping of the records and understand that the Canton Women's Center is not responsible for the loss of the USB flash drive. It is my responsibility to safeguard my medical records provided.

_____
Patient Signature