Authorization for Release of Medical Records

Grant Arthritis and Osteoporosis Center
285 East State Street
Suite 620
Columbus, Ohio 43215
(614) 566-9380

I hereby authorize _____, located at
Physician's name (print)

_____
Address City State Zip

to furnish my medical records to **Grant Arthritis and Osteoporosis Center** at the address above for the purpose of continuity of care.

Any and all information may be released, including but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results except as specifically listed below:

_____

This authorization is effective now and will remain in effect until _____.

I understand that I have the right to receive a copy of this authorization.

_____
Signature Date of signature

_____
Printed Name of Patient

_____
Address City State Zip

_____
Patient's Date of Birth

If not signed by patient, please indicate relationship to patient:
__ parent or guardian of minor patient
__ guardian or conservator of an incompetent patient
__ beneficiary or personal representative of deceased patient