Individual Care Center

Phone: (513) 774-9444

8833icare@gmail.com

www.IndividualCareCenter.net

Authorization to Release Health Care Information

Patient Name: _____ Date of Birth: _____

I hereby request and authorize the Individual Care Center to release my health care information and medical records to the following entities:

Name of provider or institution #1: _____

Phone #: _____ Fax #: _____

This request and authorization apply to all of my health information that Dr. Soliman (Individual Care Center) has, including information related to any medical history, laboratory results, mental health treatment, and/or substance abuse treatment.

As a courtesy, there will be no charge associated with **faxing** necessary medical records to another provider/institution for the purpose of continuing my medical care. However, there will be charges associated with **mailing** medical records to another provider/institution or if you need a copy of your medical records for yourself or your representative. All fees are set by the state of Ohio. All applicable fees must be collected and cleared before your medical record is sent.

This consent is a one-time authorization and expires automatically once your medical records are sent to the above entities. I understand that once this signed consent is received by Dr. Soliman (Individual Care Center), I cannot reverse or cancel it.

My signature below affirms that I have read the contents of this release or it has been read to me, and I understand and agree with its content.

Patient/Representative Signature: _____ Date: _____