Northeast Ohio
MEDICAL UNIVERSITY

STUDENT CONSENT TO RELEASE MEDICAL RECORDS AND/OR DISCUSS MATTERS WITH A TREATING PROVIDER

_____ College: _____

LAST FIRST MI

Graduation Year: _____

Mailing Address: _____ Cell Phone #: _____

City, State, Zip:_____ Email: _____

I hereby authorize Northeast Ohio Medical University (NEOMED) to receive and/or discuss my medical record information including, but not limited to, dates of treatment, history of illness, diagnostic, therapeutic, or pharmacological treatment with my treating provider. I understand that the medical records to be received by or discussions to occur with NEOMED staff may contain medical information pertaining to psychiatric, drug and/or alcohol and diagnosis and treatment. The personal medical information released to NEOMED will be shared on a need-to-know basis and will not be shared with any individuals beyond the purposes specified with this release. The purpose for the release of such information is as follows:

_____.

Student Signature:_____ Date: _____

This authorization and release is effective for twelve (12) months from the date set forth above.

COMPLETE THIS SECTION <u>ONLY</u> IF MEDICAL RECORDS ARE TO BE SUBMITTED TO NEOMED

Please release records covering the time period for _____ to _____

Information to be released:

( ) Complete copy of my record ( ) Abstract only

( ) Office or treatment notes only ( ) Other _____

Please direct my medical records to the following person/department at NEOMED:

_____ _____

Phone: _____ Fax: _____

Address: Northeast Ohio Medical University
4209 State Route 44, P.O, Box 95
Rootstown, OH 44272

Attn: (same as person/department identified above)