1) **PATIENT INFORMATION**:

Full Name (First, Middle Initial, Last _____ Date of Birth _____

Previous Name/Other Alias (if applicable) _____

Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening/Other Phone _____

2) **TO DISCLOSE RECORDS TO**:

☐Self - Mail to address above

☐Other _____
Name of Company or Other Recipient

Address _____ City _____ State _____ Zip _____

3) **INFORMATION TO BE DISCLOSED**:

☐ Trip Number: _____

☐ Date of Service: _____

☐ Account Number: _____

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____

DRIVER'S LICENSE NUMBER: _____

According to established legal requirements, as custodians of protected health information, we are unable to release any record without a signed, written authorization from the patient or his/her legal representative. To facilitate this process, please sign and return this letter confirming that you authorize a copy of the above medical record(s) for release. Please include a copy of the front and back of your driver's license or state identification.

If you are the patient's conservator, have medical power of attorney, or are his/her executor, please provide a copy of the supporting legal documentation. You must also include a copy of the patient's death certificate and a copy of your driver's license or state identification, so we can expedite your request. Records will be mailed to the patient's address unless noted otherwise above.

If you have any further questions or concerns regarding this account, please contact our customer service department at 1-800-913-9106 for assistance.

Please remit to: CENTREX REVENUE SOLUTIONS
50 SOUTH MAIN STREET, SUITE 401
AKRON, OH 44308