AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Client Name Date of Birth Social Security №.

I,_____, hereby authorize the release of any and all medical information and all records from physicians, psychiatrists, psychologists, counselors, social workers, therapists and any individuals providing health care, as well as any hospitals, clinics, doctor's offices, or health care providers including those listed below to the City of Columbus, City Attorney Richard C. Pfeiffer's office, and any Assistant City Attorney, and/or their agents.

- ☑ Outpatient treatment records for physical and psychological, psychiatric, emotional illness, or drug and/or alcohol abuse.
- ☑ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☑ Treatment, recovery, rehabilitation, aftercare plans, and other similar plans.
- ☑ Social, family, educational, and vocational plans.
- ☑ Social work assessments and plans.
- ☑ Progress, nursing, case, or similar notes.
- ☑ Billing/Financial records.
- ☑ Information about how the patient's condition(s) affects or has affected his/her ability to work and to complete tasks or activities of daily living.
- ☑ Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- ☑ HIV related information and drug and alcohol information.

For the date(s) of care beginning January 2011 to the present.

The information will be used only for purposes relating to a claim I have filed against the City of Columbus, Ohio. The authorization for release shall expire upon final adjudication of the

aforementioned action. Any and all records shall be released to the City of Columbus, City Attorney Richard C. Pfeiffer's office, and any Assistant City Attorney, and/or their agents, located at 77 N. Front Street, Columbus Ohio, 43215.

I have the right to revoke this authorization at any time provided that said revocation is in writing and delivered to the City of Columbus, City Attorney Richard C. Pfeiffer except to the extent that the City of Columbus has taken action in reliance of said authorization.

I realize the potential for information disclosed pursuant to this authorization to be subject to disclosure by the recipient and to no longer be protected by the Privacy Rule of the Health Insurance Portability and Accountability Act.

A copy of this authorization is valid as the original.

_____ _____

DATE SIGNATURE

STATE OF OHIO,
COUNTY OF FRANKLIN, SS:

SWORN TO BEFORE ME and subscribed in my presence the _____day of _____, 20__.

_____

NOTARY PUBLIC, STATE OF OHIO