FAIRFIELD MEDICAL ASSOCIATES, LLC
BOARD CERTIFIED PHYSICIANS
SARAH J. ALLEY, M.D.
MICHELLE L. GRAHAM, M.D.
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JILL A. SCHELLHASE, M.D.

AUTHORIZATION FOR USE AND DISCLOSURE OR MEDICAL INFORMATION

Patient Name: ____ Date of Birth: ________________

Address: ____ Soc. Sec. #: _________________

City/State/Zip: ____ Phone: _____________________

I hereby authorize:

Dr.____________
1781 Countryside Dr. Lancaster, OH 43130
Phone: (740) 687-8600 Fax: (740) 475-0598

To Release To:

Name: ____ Phone: __________________________

Address: ____

USE: ________ Continuity of Patient Care ______Transferring Patient Care
________ Insurance/Third Party Reimbursement ______ Other

INFORMATION REQUESTED	SERVICE TYPE	DATE(S)	TYPE OF INFORMATION
	___ INPATIENT	_______	_______________________
	___ OUTPATIENT	_______	_______________________
	___ EMERGENCY	_______	_______________________
	___ OTHER	_______	_______________________

SIGNATURE____ DATE: __________________
Patient must sign if 18 or older

RELATIONSHIP: ____ PARENT ____ LEGAL GUARDIAN ____ EXECUTOR OF ESTATE