FAIRFIELD MEDICAL ASSOCIATES, LLC

BOARD CERTIFIED PHYSICIANS

SARAH J. ALLEY, M.D.

MICHELLE L. GRAHAM, M.D.

AGNES M. LAUS, M.D., F.A.A.P.

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:

Name: ____ Phone: _________________________

Address: ____

To Release To:

Dr. _______________________
Fairfield Medical Associates
1781 Countryside Drive
Lancaster, OH 43130
Phone: (740) 687-8600
Fax: (740) 475-0598

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