System Optics, Inc./Novus Clinic
Authorization for Release of Information
Medical Records Department
518 West Avenue, Tallmadge, OH 44278
Phone: 330-630-9699 Fax: 330-630-3206

Patient Information:
Print Name:_____ Date of Birth:_____
SS#:_____ Maiden or Prior Name:_____

Please release my healthcare information from:
Name of Facility/Provider:
_____
Address:_____
City/State/Zip: _____
Phone: _____

Please send my healthcare information to:
Name of designated recipient:
_____
Address:_____
City/State/Zip: _____
Phone: _____ Fax: _____

Information to be released

- ❑ The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests)
- ❑ All medical records
- ❑ Specific information (please specify) _____

Purpose for which disclosure is being made:

- ❑ Sharing with other healthcare providers
- ❑ Personal use
- ❑ Legal investigation
- ❑ I am transferring my care to a new healthcare provider
- ❑ Other: _____

Patient Authorization

I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. The Novus Clinic is specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Fees for Copying Medical Records

Our charges are per page as follows: $3.25 for the first ten pages, $0.68 for pages 11-50, $0.27 for pages 51- higher. Plus actual cost of postage incurred. These fees must be paid before your records can be released. Ohio Revised Code Section 3701.742

I understand that I may be charged at the rates shown above for the copies of the records. I have requested and for postage, if needed. I agree to pay the total charges upon receipt of the copies

Signature: _____ Date:_____
(Parent, Guardian*, Authorized Representative*-*Please provide documents to prove authority to sign on behalf of the patient)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED

Novus Clinic record release form Updated: 04/10/2019