Release of Records to Dr Marchetti

Part A- Patient Information- (please print)

____ ____________________

Name (First, MI, Last) **Date of Birth**

____ ___________________

Address (street, city, state, zip code) **Daytime phone number**

Part B – Previous Physician/Practice Information

I authorize the following physician/practice to release the information specified below in Part C

Practice Name:____

Address:____

Part C – Information to be Released

I authorize the physician/medical practice in Part B to release the following (circle one):

Summary/Explanation Specific information:_____________

Immunization records ________________________________

Three year pertinent history Entire medical record

I understand that the medical record may contain information regarding ***psychiatric disorders, drug/alcohol abuse, HIV test results, a diagnosis of AIDS or an AIDS related condition****, and I expressly consent to the release of any such information in the records designated above.*

Part D – Recipient of Information

Forward a copy of the information specified in Part C to:

Pennie Marchetti, MD
1355B Corporate Drive
Hudson, Ohio 44236
330-653-3157 (phone)
330-653-3170(fax)

Patient Signature:____ Date:_________________
Printed Name ____

Patient Representative_____________________________________ Date:_________________
Printed name of representative____