

**RELEASE OF INFORMATION**

I, the undersigned \_\_\_\_\_, DOB \_\_\_\_\_

Do hereby authorize the release of my medical records from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the release of these specific records:

\_\_\_\_\_  
\_\_\_\_\_

For the following reason(s):

\_\_\_\_\_

I authorize the release of my records to Richard F. Gaeke MD, FACP of  
Medical Associates of Middletown, Inc.  
42 N. Breiel Blvd.  
Middletown, OH 45042  
513-422-0024

This authorization will expire: \_\_\_\_\_  
If no date/event is given, this will expire 180 days from the date of my signature.

This release has no limitations, unless otherwise specified, and may include information relating to diagnosis and treatment of psychiatric illness, alcohol or drug abuse, HIV/ARC/AIDS, and other communicable disease. I understand that authorization for disclosure of this information is voluntary and that I can refuse to sign this release. I may revoke this authorization in writing at any time, except to the extent that either party has already acted based on this authorization.

I realize that such a release of medical records is for medical purposes only and that the confidentiality of my records will be respected. I also understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to signature