

AUTHORIZATION TO RELEASE INFORMATION

MR

PATIENT INFORMATION	LAST NAME		FIRST	MIDDLE	MAIDEN	
	ADDRESS			CITY	STATE	ZIP
	DOB	SOC.SEC.	WORK PHONE		HOME PHONE	
REASON NEEDED	PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:					
	<input type="checkbox"/> MEDICAL TREATMENT <input type="checkbox"/> DISABILITY <input type="checkbox"/> CONTINUITY OF CARE (Minimum Data Set section below) <input type="checkbox"/> CHANGING DOCTOR / MOVING FROM AREA <input type="checkbox"/> OTHER (Specify) _____			<input type="checkbox"/> EMPLOYMENT RELATED <input type="checkbox"/> INSURANCE <input type="checkbox"/> LEGAL REASONS <input type="checkbox"/> ADOPTION PLANNING <input type="checkbox"/> RESEARCH		
INFORMATION NEEDED	INFORMATION TO BE DISCLOSED: <input type="checkbox"/> Riverside Health Center <input type="checkbox"/> Riverside Methodist Hospital <input type="checkbox"/> Grant Medical Center <input type="checkbox"/> Grady Memorial Hospital <input type="checkbox"/> Doctors Hospital <input type="checkbox"/> McConnell Health Center <input type="checkbox"/> Dublin Methodist Hospital					
	SPECIFY TYPE OF RECORDS REQUESTED: DATE OF SERVICE: _____ <input type="checkbox"/> INPATIENT _____ <input type="checkbox"/> OUTPATIENT CARE CLINICS _____ <input type="checkbox"/> EMERGENCY ROOM _____ <input type="checkbox"/> OUTPATIENT _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DATES/SERVICES TO BE EXCLUDED FROM RELEASE (i.e. <i>HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC AND OR DRUG/ALCOHOL TREATMENT that may be in your medical record.)</i> Please specify : _____					
RECORDS/DOCUMENTS (CONTENT)	For the record(s) selected above, specify content in area below, as either, Complete Record, Minimum Document Set or Additional Document Set.					
	<input type="checkbox"/> COMPLETE RECORD	<input type="checkbox"/> MINIMUM DOCUMENT SET (check one or more of the documents, or all) <input type="checkbox"/> FACESHEET <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> HISTORY AND PHYSICAL <input type="checkbox"/> CONSULTS <input type="checkbox"/> OPERATIVE REPORTS <input type="checkbox"/> EMERGENCY DEPT. REPORTS <input type="checkbox"/> PATHOLOGY <input type="checkbox"/> TEST RESULTS (labs, radiology, EKGs, EEGs, Echo) <input type="checkbox"/> OTHER _____ <input type="checkbox"/> ALL OF THE ABOVE			<input type="checkbox"/> ADDITIONAL DOCUMENT SET (comprised of Minimum Document Set, plus each of the following if selected): <input type="checkbox"/> PHYSICIAN ORDERS <input type="checkbox"/> PROGRESS NOTES <input type="checkbox"/> NURSING NOTES <input type="checkbox"/> GRAPHICS <input type="checkbox"/> PHYSICAL THERAPY/ SOCIAL SERVICE NOTES <input type="checkbox"/> NUTRITION SERVICES NOTES <input type="checkbox"/> CONSENTS <input type="checkbox"/> MEDICATION LISTS <input type="checkbox"/> ANESTHESIA RECORDS/ OTHER SURGERY DOCUMENTS <input type="checkbox"/> OTHER/MISC. _____	
Each type of record may or may not contain all of the documents listed above.						
ACTION	<input type="checkbox"/> MAIL (IF YES, COMPLETE ADDRESS BELOW)		<input type="checkbox"/> REVIEW ONLY DATE/TIME: _____	<input type="checkbox"/> Pick up (Hospital will call when ready) DATE/TIME: _____	<input type="checkbox"/> VERBAL EXCHANGE	<input type="checkbox"/> FAX FAX# _____
	DISCLOSE INFORMATION TO THE FOLLOWING:				Attn: (Insert Name)	
	ORGANIZATION/ AGENCY					
	ADDRESS			CITY	STATE	ZIP
PHONE#			FAX#			

PATIENT IDENTIFICATION LABEL



**AUTHORIZATION TO
RELEASE INFORMATION**
Chart Tab: *CONSENT*

- Riverside Health Center
500 Thomas Lane
Columbus, OH 43214
(614) 566-5000
- Riverside Methodist Hospital
3535 Olentangy River Road
Columbus, OH 43214
(614) 566-5000
- Grant Medical Center
111 South Grant
Columbus, OH 43215
(614) 566-9000
- Grady Memorial Hospital
561 W. Central Ave
Delaware, Ohio 43015
(740) 368-5140
- Doctors Hospital
5100 W. Broad Street
Columbus, Ohio 43228
(614) 544-1000
- McConnell Health Center
3773 Olentangy River Rd
Columbus, Oh 43214
(614) 566-5356
- Dublin Methodist Hospital
7500 Hospital Drive
Dublin, OH 43016
(614) 544-8000

MR _____

THIS AUTHORIZATION FOR RELEASE OF INFORMATION FOR THE DATE OF SERVICE INDICATED ON THE PREVIOUS PAGE IS EFFECTIVE UNTIL _____ OR FOR A MAXIMUM OF 1 YEAR FROM THE DATE SIGNED BELOW
(TIME/CONDITION)

I HEREBY AUTHORIZE

OHIOHEALTH HOSPITALS / FACILITIES

NAME OF PHYSICIAN

(if requesting your physician office records)

ADDRESS, CITY, STATE, ZIP

FAX#

PHONE#

AUTHORIZATION AND EXPIRATION

I understand that this authorization may include information concerning testing, diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC AND OR DRUG/ALCOHOL TREATMENT that may be in my medical record.

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that treatment or payment of my claim will not be impacted by not signing this form. Research related treatment is strictly voluntary. I understand that by signing this authorization it gives the researcher(s) the permission to use or disclosure my personal health information for such research. I understand that my records cannot be released unless I sign this form.

As described in the Notice of Privacy Practices of (Entity Name), I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by (Entity Name) in reliance on this authorization, by sending a written revocation to: (Entity's) Medical Record Department, (Entity's address.) ATTN: Information Associate.

I HEREBY AUTHORIZE ENTITY NAME TO DISCLOSE TO THE PARTY (PARTIES) NAMED ON THE PREVIOUS PAGE, INFORMATION FROM MY MEDICAL RECORD FOR THE REASONS AND TIME SPECIFIED.

SIGNATURE OF PATIENT

X

DATE

SIGNATURE OF INDIVIDUAL AUTHORIZED BY PATIENT

DATE

RELATIONSHIP TO PATIENT

PROHIBITION ON REDISCLOSURE: this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal Law.

NOTIFICATION/FEEES

According to Ohio Revised Codes there is a per page fee for records. The fee will be dependent upon the number of copies requested and other reasons as specified in ORC 3701.741 at www.codes.ohio.gov/ORC.

Optional: If you wish to be notified by e-mail regarding the status of your request please provide us with your e-mail address.

E-mail: _____



PATIENT IDENTIFICATION LABEL

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