

EXCHANGE OF INFORMATION AUTHORIZATION

Riverside/John J. Gerlach Center for Senior Health 3724-A Olentangy River Road, Columbus, OH 43214 614-566-5858

PATIENT INFORMATION	LAST NAME FIRST MIDDLE MAIDEN			
	ADDRESS		CITY	STATE ZIP
	BIRTHDATE	SOC. SEC. #	WORK PHONE	HOME PHONE
INFORMATION NEEDED	<input type="checkbox"/> INPATIENT _____ <input type="checkbox"/> OUTPATIENT SURGERY _____ <input type="checkbox"/> OUTPATIENT CARE CENTER _____ <input type="checkbox"/> OUTPATIENT _____ <input type="checkbox"/> OTHER (SPECIFY DEPT.) _____		DATE OF SERVICE _____ <input type="checkbox"/> ALL RECORDS FOR THE LAST 12 MONTHS <input type="checkbox"/> OTHER _____ _____ _____	
	<input type="checkbox"/> REVIEW ONLY DATE/TIME _____ <input type="checkbox"/> PICK UP-NEEDED Date/Time _____		<input type="checkbox"/> MAIL COPIES <input type="checkbox"/> FAX Fax # (614) 566-1916 <input type="checkbox"/> VERBAL EXCHANGE	
SEND TO/ RECEIVE FROM	Organization/Agency PRIMARY CARE DOCTOR		Attn: (insert primary care doctor's name)	
	ADDRESS		CITY	STATE ZIP
	PHONE #		FAX #	
REASON NEEDED	Please Specify the Reason(s) for Your Request			
	<input type="checkbox"/> MEDICAL TREATMENT <input type="checkbox"/> LEGAL REASONS <input type="checkbox"/> EMPLOYMENT RELATED <input type="checkbox"/> DISABILITY <input type="checkbox"/> CHANGING DOCTOR/MOVING <input type="checkbox"/> INSURANCE <input checked="" type="checkbox"/> OTHER (SPECIFY) <u>Assistance with Evaluation/Continuity of Care</u>			
AUTHORIZATION AND EXPIRATION	THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS EFFECTIVE UNTIL <u>1 YEAR</u> FROM THE DATE SIGNED BELOW. <p align="center">(TIME/CONDITION)</p>			
	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 any claims 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 disclose 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 Riverside Methodist Hospital, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Riverside Methodist Hospital in reliance on this authorization, by sending a written revocation to the address at the top of this form.			
	I hereby authorize Riverside Senior Health Services to disclose to the party (parties) named above, information from my medical records for the reasons and time specified.			
SIGNATURE OF PATIENT X			DATE X	
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PATIENT			DATE	
RELATIONSHIP TO PATIENT				
<p>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.</p>				