Riverside Methodist Hospital
OhioHealth

EXCHANGE OF INFORMATION AUTHORIZATION

Riverside/John J. Gerlach Center for Senior Health 3830 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

DATE OF SERVICE

- ☐ INPATIENT _____
- ☐ OUTPATIENT SURGERY _____
- ☐ OUTPATIENT CARE CENTER _____
- ☐ OUTPATIENT _____
- ☐ OTHER (SPECIFY DEPT.) _____

- ☐ **ALL RECORDS FOR THE LAST 12 MONTHS**
- ☐ OTHER
  Scans, x-rays, labs, H & P notes

SEND TO/ RECEIVE FROM

☐ REVIEW ONLY DATE/TIME	☐ PICK UP-NEEDED Date/Time	☐ MAIL COPIES	☐ FAX Fax # (614) 566-1916	☐ VERBAL EXCHANGE

PRIMARY CARE PHYSICIAN

NAME:			
ADDRESS	CITY	STATE	ZIP
PHONE #	FAX #		

REASON NEEDED

Please Specify the Reason(s) for Your Request

- ☐ MEDICAL TREATMENT
- ☐ LEGAL REASONS
- ☐ EMPLOYMENT RELATED
- ☐ DISABILITY
- ☐ CHANGING DOCTOR/MOVING
- ☐ INSURANCE
- X OTHER (SPECIFY) **Assistance with Evaluation/Continuity of Care**

AUTHORIZATION AND EXPIRATION

THIS AUTHORIZATION FOR RELEASE OF INFORMATION IS EFFECTIVE UNTIL 3 YEARS FROM THE DATE SIGNED BELOW.

(TIME/CONDITION)

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	

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.

08/15/2017

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Patient Info	Last Name	First	Middle	Date of Birth

Information Needed	**Specify Department** ☒ Outpatient- Other JOHN J. GERLACH CENTER	**Reports Requested** ☒ Any verbal and/or written exchanges related to comprehensive geriatric assessment consultation and related care/testing

Send To/Receive From

Names (Of All Persons Authorized to Receive/Review Information and/or to Provide Information)

NAME	RELATIONSHIP TO PATIENT	PRIMARY & SECONDARY PHONE #

Authorization and Expiration

THIS AUTHORIZATION FOR RELEASE OF INFORMATION WILL EXPIRE IN 3 YEARS OR WHEN THE PATIENT IS NO LONGER A PATIENT AT THE GERLACH CENTER, WHICHEVER IS SOONER. IT MAY BE REVOKED AT ANY TIME IN WRITING.

I HEREBY AUTHORIZE RIVERSIDE /GERLACH CENTER FOR SENIOR HEALTH / RIVERSIDE METHODIST HOSPITALS/ OHIO HEALTH TO EXCHANGE WITH THE PARTY (PARTIES) NAMED ABOVE, INFORMATION FROM MY MEDICAL RECORD UNTIL THE TIME SPECIFIED ABOVE.

I UNDERSTAND THAT THIS AUTHORIZATION MAY INCLUDE INFORMATION CONCERNING TESTING, DIAGNOSIS OR TREATMENT IN MY MEDICAL RECORD.

I UNDERSTAND THAT IF THE PERSON OR ENTITY INVOLVED IN THE EXCHANGE OF THE ABOVE INFORMATION IS NOT A HEALTH CARE PROVIDER OR HEALTH PLAN COVERED BY FEDERAL PRIVACY REGULATIONS, THE INFORMATION DESCRIBED ABOVE MAY BE REDISCOLOSED BY SUCH PERSON OR ENTITY AND WILL LIKELY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATION.

I UNDERSTAND THAT TREATMENT OR PAYMENT OF MY CLAIM WILL NOT BE IMPACTED BY NOT SIGNING THIS FORM.

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, ATTN: ADMINISTRATIVE ASSISTANT.

Signature of Patient X	DATE X
Signature of Individual Authorized by Patient	Date
Relationship to Patient	

Prohibition of Redisclosure: Information that 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 this law shall be subject to prosecution under Federal Law.

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