

AUTHORIZATION TO RELEASE OF INFORMATION

1. PATIENT INFORMATION			MRN (OFFICE USE ONLY):		
LAST NAME	FIRST	MIDDLE	MAIDEN		
ADDRESS			CITY	STATE	ZIP
DOB	SSN (LAST 4 DIGITS)	PREFERRED PHONE		<input type="checkbox"/> LEAVE MESSAGE (CHECK TO LEAVE MESSAGE)	

2. REASON FOR REQUEST

CONTINUITY OF CARE - MEDICAL TREATMENT
 INSURANCE
 LEGAL REASONS
 DISABILITY
 RESEARCH
 ADOPTION
 EMPLOYMENT RELATED
 Other (Describe) _____

3. INFORMATION TO BE DISCLOSED BY:

<input type="checkbox"/> BERGER HOSPITAL	<input type="checkbox"/> GROVE CITY METHODIST HOSPITAL	<input type="checkbox"/> RIVERSIDE METHODIST HOSPITAL
<input type="checkbox"/> DOCTORS HOSPITAL	<input type="checkbox"/> HARDIN MEMORIAL	<input type="checkbox"/> SHELBY HOSPITAL
<input type="checkbox"/> DUBLIN METHODIST HOSPITAL	<input type="checkbox"/> MANSFIELD HOSPITAL	<input type="checkbox"/> PHYSICIAN OFFICE (SPECIFY) _____
<input type="checkbox"/> GRADY MEMORIAL HOSPITAL	<input type="checkbox"/> MARION GENERAL HOSPITAL	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> GRANT MEDICAL CENTER	<input type="checkbox"/> O'BLENESS HOSPITAL	

4. DATES OF SERVICE TO BE RELEASED:

DATE/YEAR OF SERVICE(S): FROM _____ TO _____

5. RECORDS TO BE RELEASED (CHECK ALL THAT APPLY):

<input type="checkbox"/> AFTER VISIT SUMMARY	<input type="checkbox"/> OPERATIVE REPORT(S)	PLEASE SPECIFY: <input type="checkbox"/> RESULTS: _____ <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> PHYSICIAN OFFICE NOTES: _____
<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> EMERGENCY DEPT. REPORT(S)	
<input type="checkbox"/> HISTORY AND PHYSICAL	<input type="checkbox"/> PATHOLOGY	
<input type="checkbox"/> CONSULTS	<input type="checkbox"/> COMPLETE RECORD	

6. DELIVERY METHOD:

<input type="checkbox"/> US MAIL	<input type="checkbox"/> PICK-UP	<input type="checkbox"/> CD	The CD/email you have requested is encrypted. If you agree to have the encryption removed by OhioHealth, please initial below. By removing the encryption, your personal health information will no longer be secured. INITIALS: _____
<input type="checkbox"/> EMAIL (limited per file size)	<input type="checkbox"/> MYCHART	<input type="checkbox"/> CIOX E-PORTAL	
Email Address _____			

7. RELEASE TO:

NAME OF PERSON/ORGANIZATION/CLINIC: _____ Self

ADDRESS:	CITY:	STATE:	ZIP:
PHONE:	FAX:		

8. PROHIBITION ON REDISCLOSURE:

I understand this information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR part 2) may 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.

9. FEES: Per Ohio Revised Codes and HIPAA, there may be a charge for copying medical records

10. AUTHORIZATION AND EXPIRATION:

+ 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 privacy regulations.

+ OhioHealth will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign the authorization when the prohibition on condition of authorizations applies.

+ I understand 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/protected health information cannot be released unless I sign this form.

+ **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 and/or ASSAULT RECORDS that may be in my medical record.**

+ As described in the Notice of Privacy Practices of OhioHealth, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by OhioHealth in reliance on this authorization, by sending a written revocation to the entity's Health Information Management Medical Records Department. If this authorization has not been revoked, it will expire on the date or event stated below. If no date is specified below, the authorization will remain in effect for a maximum of one year.

Expiration Date or Event: _____

X Signature of Patient _____ Date _____ Time _____

Signature of Individual Authorized by Patient _____ Date _____ Time _____

Relationship to Patient _____



ROI

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RELEASE OF INFORMATION**

PATIENT IDENTIFICATION LABEL