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	❑ 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 (please specify location in space provided):

❑ HOSPITAL _____ ❑ HEALTH CENTER _____
❑ FREESTANDING ED _____ ❑ PHYSICIAN OFFICE _____
❑ URGENT CARE _____ ❑ OTHER: _____
❑ ALL OHIOHEALTH LOCATIONS

4. DATES OF SERVICE TO BE RELEASED:

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

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

❑ AFTER VISIT SUMMARY
❑ DISCHARGE SUMMARY
❑ HISTORY AND PHYSICAL
❑ CONSULTS
❑ LABS
❑ OPERATIVE REPORT(S)
❑ EMERGENCY DEPT. REPORT(S)
❑ PATHOLOGY
❑ RADIOLOGY/IMAGES
❑ IMAGES ❑ RADIOLOGY REPORT
❑ RECORD SUMMARY (INCLUDES, BUT NOT LIMITED TO, ITEMS ABOVE)

PLEASE SPECIFY:
❑ RESULTS: _____
❑ OTHER: _____
❑ PHYSICIAN OFFICE NOTES: _____

6. DELIVERY METHOD: ❑ US MAIL ❑ PICK-UP ❑ MYCHART ❑ PATIENT E-PORTAL/eDelivery (Provide email below).
❑ EMAIL (Limited per file size. If records exceed file size, records will be delivered via eDelivery) ❑ CD (Unless a pickup location is selected below, CDs will be sent via US Mail).

If pick up was selected, please indicate which location **(Limited to below locations; Please select below) (Medical record only requests at these locations)**
❑ Riverside Methodist Hospital ❑ Grant Medical Center ❑ Mansfield Hospital

Radiology images: ❑ CD US Mail ❑ Email Link ❑ CD Pickup_____ (Indicate location)

The CD/email you have requested is encrypted. If you agree to have the encryption removed by OH, please initial below. By removing the encryption, your personal health information will no longer be secured. (Medical record requests only).

INITIALS: _____ **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 _____

OhioHealth

ROI

AUTHORIZATION TO RELEASE OF INFORMATION

PATIENT IDENTIFICATION LABEL