Authorization to Release Information

MRN

1. PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	MAIDEN

ADDRESS	CITY	STATE	ZIP

DOB	SOC.SEC.	WORK PHONE	HOME PHONE

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

- ❒ CONTINUITY OF CARE / MEDICAL TREATMENT (Minimum Document Set section below)
- ❒ DISABILITY(Minimum Document Set section below)
- ❒ CONTINUITY OF CARE (Minimum Document Set section below)
- ❒ CHANGING DOCTOR / MOVING FROM AREA (Minimum Document Set section below)
- ❒ OTHER (Specify)___________________________
- ❒ PUBLIC DISCLOSURE OF PROTECTED HEALTH INFORMATION (IF yes- SKIP TO SECTION 6)
- ❒ EMPLOYMENT RELATED
- ❒ INSURANCE
- ❒ LEGAL REASONS
- ❒ ADOPTION PLANNING
- ❒ RESEARCH

3. INFORMATION NEEDED

INFORMATION TO BE DISCLOSED FROM: (check as many as applicable)

- ❒ Riverside Health Center
- ❒ Riverside Methodist Hospital
- ❒ Grant Medical Center
- ❒ Grady Memorial Hospital
- ❒ O'Bleness Hospital
- ❒ Doctors Hospital
- ❒ McConnell Health Center
- ❒ Dublin Methodist Hospital
- ❒ OhioHealth Home Care
- ❒ MedCentral Hospital
- ❒ Hardin Memorial Hospital
- ❒ Marion General Hospital
- ❒ Gerlach Center
- ❒ Westerville Medical Campus
- ❒ Shelby Hospital
- ❒ OhioHealth Nelsonville Medical and Emergency Services
- ❒ OhioHealth Physicians Group (name of practice/provider)______________________
- ❒ Marion Area Physicians
- ❒ Outpatient /Neighborhood Care Health Centers (name of practice/provider) ______________________
- ❒ Other ____

SPECIFY TYPE OF RECORD REQUESTED:	**DATE OF SERVICE(S):**
❒ INPATIENT	______________________
❒ OUTPATIENT CARE CLINICS	______________________
❒ EMERGENCY ROOM	______________________
❒ OUTPATIENT	______________________
❒ OTHER	______________________

❒ DATES/SERVICES TO BE EXCLUDED FROM RELEASE (i.e. ***HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC, OR DRUG/ALCOHOL TREATMENT AND/OR ASSAULT RECORDS that may be in your medical record.***
Please specify : ____

4. RECORDS/DOCUMENTS (CONTENT)

Content to be Released – For the record(s) selected above, specify content in area below, as either, Complete Record, minimum document set or additional document set. Each type of record may or may not contain all of the documents listed above.

❒ **COMPLETE RECORD**

MINIMUM DOCUMENT SET (check one or more of the documents, or all)

- ❒ FACESHEET
- ❒ DISCHARGE SUMMARY
- ❒ HISTORY AND PHYSICAL
- ❒ CONSULTS
- ❒ OPERATIVE REPORTS
- ❒ EMERGENCY DEPT. REPORTS
- ❒ PATHOLOGY
- ❒ TEST RESULTS (labs, radiology, EKGs, EEGs, Echo)
- ❒ OTHER ______________________
- ❒ ASSAULT RECORDS
- ❒ ALL OF THE ABOVE

ADDITIONAL DOCUMENT SET (comprised of Minimum Document Set, plus each of the following if selected):

- ❒ PHYSICIAN ORDERS
- ❒ PROGRESS NOTES
- ❒ NURSING NOTES
- ❒ GRAPHICS
- ❒ PHYSICAL THERAPY/ SOCIAL SERVICE NOTES
- ❒ NUTRITION SERVICES NOTES
- ❒ CONSENTS
- ❒ MEDICATION LISTS
- ❒ ANESTHESIA RECORDS/ OTHER SURGERY DOCUMENTS
- ❒ OTHER/MISC. ______________________

5. ACTIONS FOR STAFF TO TAKE

MAIL TO ORGANIZATION/ AGENCY	ATTN:

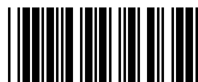
ADDRESS	CITY	STATE	ZIP

PHONE#

❑ Review Only (DATE AND TIME) _______________ ❑ DATE RECORDS WILL BE READY FOR PICK-UP ______________________ ❑ VERBAL EXCHANGE

❑ FAX TO: Fax # ❑ Release to MyChart

PATIENT IDENTIFICATION LABEL



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6. MEDIA PUBLIC DISCLOSURE

For Marketing and Communications Use Only.

I AUTHORIZE THE PUBLIC DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED BELOW:

❑ name and age ❑ city of residence ❑ hospital admission, discharge or treated/released status

❑ brief extent of injuries or illness ❑ diagnosis, treatment, prognosis ❑ photographs, videotape or audiotape

❑ other (describe) ______________________________

FOR THE PURPOSE OF: ❑ hospital produced publications/promotions/advertising ❑ hospital events/presentations/projects

❑ hospital web-site ❑ educational purposes/professional conferences ❑ all news media

❑ other use (describe) ______________________________

7. AUTHORIZATION

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 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/protected health information cannot be released unless I sign this form.
- 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: (entity's) Medical Record Department, (entity's address.) Attn: Information Associate.

Riverside Health Center (614) 566-5000	Riverside Methodist Hospital (614) 566-5000	Grant Medical Center (614) 566-9000	Grady Memorial Hospital (740) 615-1030	Doctors Hospital (614) 544-1000	Doctors Hospital Nelsonville (740) 753-1931
Mcconnell Health Center (614) 566-5356	Dublin Methodist Hospital (614) 544-8000	OhioHealth Home Care (614) 566-0888	Marion General Hospital (740) 383-8400	Hardin Memorial Hospital (419) 673-0761	Neighborhood Care Health Center
Marion Area Physicians (740) 383-8010	OPG OH Physicians Group (614) 544-8376	O'Bleness Hospital (740) 592-9387	MedCentral Hospital (419) 526-8525	Shelby Hospital (419) 342-1715	

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.

8. EXPIRATION

This authorization for release of protected health information for the date of service indicated is effective until ___________ or for a maximum of one year from the date signed below.

I hereby authorize _________________ (name of entity) to disclose to the party (parties) named in this document, information from my medical record for the reasons and time specified.

X Signature of Patient ______________________________ Date___________ Time ___________

Signature of Individual Authorized by Patient ______________________________ Date___________ Time ___________

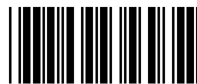
Relationship to Patient ______________________________

9. REDISCLOSURE

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) 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.

FEES

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 codes.ohio.gov/ORC.



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