

1. PATIENT INFORMATION	<b>Authorization to Release Information</b>		<b>MRN</b>			
	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:					
	<input type="checkbox"/> CONTINUITY OF CARE / MEDICAL TREATMENT (Minimum Document Set section below) <input type="checkbox"/> EMPLOYMENT RELATED <input type="checkbox"/> DISABILITY (Minimum Document Set section below) <input type="checkbox"/> INSURANCE <input type="checkbox"/> CONTINUITY OF CARE (Minimum Document Set section below) <input type="checkbox"/> LEGAL REASONS <input type="checkbox"/> CHANGING DOCTOR / MOVING FROM AREA (Minimum Document Set section below) <input type="checkbox"/> ADOPTION PLANNING <input type="checkbox"/> OTHER (Specify) _____ <input type="checkbox"/> RESEARCH <input type="checkbox"/> PUBLIC DISCLOSURE OF PROTECTED HEALTH INFORMATION (IF yes- SKIP TO SECTION 6)					
3. INFORMATION NEEDED	<b>INFORMATION TO BE DISCLOSED FROM: (check as many as applicable)</b>					
	<input type="checkbox"/> Riverside Health Center <input type="checkbox"/> Riverside Methodist Hospital <input type="checkbox"/> Grant Medical Center <input type="checkbox"/> Grady Memorial Hospital <input type="checkbox"/> Doctors Hospital <input type="checkbox"/> McConnell Health Center <input type="checkbox"/> Dublin Methodist Hospital <input type="checkbox"/> OhioHealth Home Care <input type="checkbox"/> Hardin Memorial Hospital <input type="checkbox"/> Marion General Hospital <input type="checkbox"/> Gerlach Center <input type="checkbox"/> Westerville Medical Campus <input type="checkbox"/> Doctors Hospital Nelsonville <input type="checkbox"/> OhioHealth Physicians Group (name of practice/provider) _____ <input type="checkbox"/> Marion Area Physicians <input type="checkbox"/> Outpatient /Neighborhood Care Health Centers (name of practice/provider) _____ <input type="checkbox"/> Other _____					
	<b>SPECIFY TYPE OF RECORD REQUESTED:      DATE OF SERVICE(S):</b> <input type="checkbox"/> INPATIENT _____ <input type="checkbox"/> OUTPATIENT CARE CLINICS _____ <input type="checkbox"/> EMERGENCY ROOM _____ <input type="checkbox"/> OUTPATIENT _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> DATES/SERVICES TO BE EXCLUDED FROM RELEASE ( i.e. <i>HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC, OR DRUG/ALCOHOL TREATMENT AND/OR ASSAULT RECORDS that may be in your medical record.</i> <i>Please specify :</i> _____					
4. RECORDS/DOCUMENTS (CONTENT)	<b>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.</b>					
	<input type="checkbox"/> <b>COMPLETE RECORD</b>	<b>MINIMUM DOCUMENT SET</b> (check one or more of the documents, or all) <input type="checkbox"/> FACESHEET <input type="checkbox"/> DISCHARGE SUMMARY <input type="checkbox"/> HISTORY AND PHYSICAL <input type="checkbox"/> CONSULTS <input type="checkbox"/> OPERATIVE REPORTS <input type="checkbox"/> EMERGENCY DEPT. REPORTS <input type="checkbox"/> PATHOLOGY <input type="checkbox"/> TEST RESULTS (labs, radiology, EKGs, EEGs, Echo) <input type="checkbox"/> OTHER _____ <input type="checkbox"/> ASSAULT RECORDS <input type="checkbox"/> ALL OF THE ABOVE	<b>ADDITIONAL DOCUMENT SET</b> (comprised of Minimum Document Set, plus each of the following if selected): <input type="checkbox"/> PHYSICIAN ORDERS <input type="checkbox"/> PROGRESS NOTES <input type="checkbox"/> NURSING NOTES <input type="checkbox"/> GRAPHICS <input type="checkbox"/> PHYSICAL THERAPY/ SOCIAL SERVICE NOTES <input type="checkbox"/> NUTRITION SERVICES NOTES <input type="checkbox"/> CONSENTS <input type="checkbox"/> MEDICATION LISTS <input type="checkbox"/> ANESTHESIA RECORDS/ OTHER SURGERY DOCUMENTS <input type="checkbox"/> OTHER/MISC. _____			
5. ACTIONS FOR STAFF TO TAKE	MAIL TO ORGANIZATION/ AGENCY				ATTN:	
	ADDRESS			CITY	STATE	ZIP
	PHONE#					
	<input type="checkbox"/> Review Only (DATE AND TIME) _____		<input type="checkbox"/> DATE RECORDS WILL BE READY FOR PICK-UP _____		<input type="checkbox"/> VERBAL EXCHANGE	
	<input type="checkbox"/> FAX TO: _____ Fax # _____					



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**AUTHORIZATION TO  
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*Chart Tab: CONSENT*

PATIENT IDENTIFICATION LABEL

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				

**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 \_\_\_\_\_

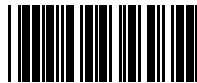
Relationship to Patient \_\_\_\_\_

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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