PROMEDICA

274

MRN # _____
*Office Use Only *

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

SS#: _____ **Telephone:** _____ **RLA #** _____
*Office Use Only *

Hospital to DISCLOSE information from:
☐ **Bay Park** ☐ **Bixby** ☐ **Herrick** ☐ **Defiance** ☐ **Flower** ☐ **Fostoria** ☐ **Toledo** ☐ **Toledo Children's** ☐ **St. Luke's** ☐ **WOSH**

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1. I am the patient listed above or the legally authorized representative of the patient listed above. I request that protected health information be released to:

Name of Person/Physician/Organization: _____
Street Address: _____
City/State/Zip: _____

2. <u>Information should be delivered via:</u>
☐ Mailed to above address ☐ On-site Review ☐ Fax: _____ ☐ Picked-up by: _____
Please note Identification is required for picked- up records

3. ☐ Description and Specific Dates of Service for Information Requested: _____
(*Also Include dates where appropriate below)*
☐ Pertinent Package (Discharge Summary, H&P, Operative Report, Consults, Labs, Rads and diagnostic testing)
☐ Progress Notes _____ ☐ Laboratory Results _____
☐ Operative Notes _____ ☐ X-rays/EKGs _____
☐ Discharge Summary _____ ☐ Entire Record _____
☐ Emergency _____ ☐ Other (specify) _____
☐ Alcohol and/or Drug abuse Treatment Program _____
☐ Sexually transmitted disease, HIV/AIDS, and/or AIDS related conditions _____
☐ Psychiatric Treatment Program _____
(<u>Psychotherapy notes are not considered part of the Psychiatric Program designated record set.</u>)

4. Purpose of Release/Disclosure:
☐ Continuation of medical care ☐ Legal Use
☐ Substantiation of payment claims/Insurance ☐ Personal Use
☐ Lab Monitoring ☐ Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. 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 could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, for Ohio entities this authorization will expire in 1 year, for Michigan entities this authorization will expire in sixty (60) days. If this authorization is for a use or disclosure of PHI for research, this authorization will expire at the end of the research study.

Signature of Patient or Legally Authorized Representative: X _____ **Date:** X _____

Relationship to Patient: _____ **Witness:** _____
If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)
☐ Parent ☐ Durable Power of Attorney for Health Care
☐ Legally Authorized Representative ☐ Personal Representative of the Estate
☐ Other (specify and attach proof) _____

FAX COMPLETED AUTHORIZATION TO: ProMedica System HIM-Release of Information 419-479-6919