ROICOR

UNIVERSITY HOSPITAL
HEALTH INFORMATION
MANAGEMENT DEPARTMENT

Authorization for Disclosure of Health Information

I hereby authorize _____ to release medical information from the records of:
(Name of Facility)

Patient Name: _____ D.O.B.: ___/___/_____ SS#: _____-____-_____

Patient Street Address: _____

City: _____ State: _____ Zip Code: _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check all applicable items to be released):

☐ Discharge Summary	☐ ER Record	☐ Progress Notes	☐ Treatment Plans
☐ Discharge Instructions	☐ X-Rays Reports	☐ Medication Records	☐ Operative Report
☐ History and Physical	☐ Lab Reports	☐ Doctor's Orders	☐ Therapy Notes
☐ Consultations	☐ EKG/ECG Tests	☐ Pathology Reports	

☐ Other (please specify):_____

Purpose Or Need For The Disclosure Is:

☐ Continued Medical Care ☐ Insurance ☐ Legal ☐ Patient's Own Use ☐ Other _____

The Information May Be Disclosed To:

Recipient's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____
(Date)

(If no date or event is specified, this authorization will expire in 60 days from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, psychiatric/psychological conditions, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

* Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____
(Signature of Patient or Personal Representative)* *(Date of Signature)*

*If signed by a personal representative, a description of the representative's authority to act is as follows:

☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney
☐ Administrator ☐ Executor of Estate ☐ Next of Kin ☐ Beneficiary

UC Health
WEST CHESTER HOSPITAL

ROI Authorization

MEDICAL RECORDS DEPARTMENT

TELEPHONE NUMBER: (513) 298-7750 FAX NUMBER: (513) 298-7765

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

TO BE USED: 1) When patient or patient's legal representative requests use or disclosure of PHI; 2) for requests by or to an entity unless exceptions apply: 3) for use and disclosure of PHI for research (when patient has not signed a research informed consent that includes authorization or researcher has not received a waiver by the I.R.B. or privacy board); and 4) when no other exceptions apply.

Protected Health Information ("PHI") under HIPAA is defined as information that is received from, or created or received on behalf of the Health Alliance and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual; and that identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; 3) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____ Maiden: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____ Phone: _____

COPIES SENT FROM/TO

Agency/Hospital	From:	To:
Name & Title of Person:	West Chester Medical Center	_____
Street Address:	7700 University Drive	_____
City, State & Zip	West Chester, OH 45069	_____

MRAUTH

UC Health
WEST CHESTER HOSPITAL

ROI Authorization

Protected Health Information To Be Used or Disclosed

Check box to indicate PHI that may be used or disclosed:

DATES
Please provide specific dates of service. Requests for "any and all" records may delay the processing of your request.

- ☐ Inpatient _____
- ☐ Emergency Department _____
- ☐ Physical Therapy _____
- ☐ Same Day Surgery _____
- ☐ Outpatient _____

Pertinent summary documents from the above visits will be sent, unless specified reports are indicated below:

- ☐ Face Sheet*
- ☐ History & Physical
- ☐ Consultation Reports*
- ☐ Discharge Summary*
- ☐ Operative Reports*
- ☐ Pathology Reports*
- ☐ Entire Record
- ☐ Lab Reports*
- ☐ X-Ray Reports*
- ☐ Diagnostic Images
- ☐ Test Reports*
- ☐ Therapy Reports
- ☐ Emergency Treatment
- ☐ Other_____

REASON NEEDED

Please specify the reason for your request:

- ☐ Medical Care
- ☐ Disability
- ☐ At My Request/Personal Reasons
- ☐ Legal Reasons
- ☐ Insurance
- ☐ Other _____

I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be redisclosed by such person/entity and will likely no longer be protected by the federal privacy regulations. I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to Medical Record Department, Release of Information, West Chester Medical Center, 7700 University Drive, West Chester, Ohio 45069.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

EXPIRATION
The authorization will expire in 60 days unless otherwise specified as: (insert date or specific event)

_____

I hereby authorize the use of disclosure of may protected health information as described above. I authorize the hospital to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV).

_____ _____
Patient/Legal Representative* Date

*Reason Patient is unable to sign: _____

*Describe scope of authority to act for patient: _____
Provide guardianship, executor of estate, power of attorney papers

_____ _____
Witness Signature Date

Retain original copy in Medical Records. Copy to patient or legal representative.

MRAUTH

UC Health

Hospital/Facility
Telephone Number (513)418-2915

Drake Center
Fax Number (513)418-2533

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Last Name_____ First Name_____ Middle_____ Maiden _____

Address _____ City _____ State_____ Zip_____

Date of Birth _____ Social Security No._____ Phone _____

Cell _____

COPIES SENT TO

Agency/Hospital _____

Name of Person _____ Title _____

Street Address _____

City _____ State_____ Zip _____

PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

Check box to indicate PHI that maybe used or disclosed:

Dates _____

_____ Inpatient
_____ Outpatient

Pertinent summary documents (*) from the above visits will be sent, unless specified reports are indicated below:

- o Face Sheet*
- o History & Physical
- o Consultation Reports*
- o Discharge Summary*
- o Other _____
- o Lab Report*
- o X-Ray Report*
- o Diagnostic Images
- o Test Reports*
- o Therapy Reports

REASON NEEDED

- ○ Medical Care
- ○ Disability
- ○ At My Request/Personal Reasons
- ○ Legal Reasons
- ○ Insurance
- ○ Other _____

I understand that if the person/ entity that receives the above protected health information is not a health care provider/ health plan covered by federal privacy regulations, the protected health information described above maybe re-disclosed by such person/ entity and will likely no longer be protected by the federal privacy regulations.

I understand that I/ my legal representative may revoke the authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to Drake Center Inpatient Medical Records Department, 151 W. Galbraith Road, Cincinnati Ohio 45216.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

EXPIRATION

This authorization will expire in 60 days unless otherwise specified (insert date or specific event) _____

I hereby authorize the use of disclosure of my protected health information as described above. I authorize the hospital to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/ psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/ or test for antibodies to the AIDS virus (HIV)

_____ _____

Patient/ Legal Representative* Date

*Reason Patient is unable to sign _____

*Describe scope of authority to act for Patient _____

Provide guardianship, executor of estate, power of attorney papers

_____ _____

Witness Signature Date