

## Authorization to Release Medical Information

<b>Patient Name (First, Middle, Last)</b>	<b>Date of Birth:</b>	<b>Last 4 digits of Patient's Social Security Number:</b>	<b>Telephone Number:</b> (     )
<b>Dates of Service to Release</b> (From): _____ (To): _____			
<b>Specific Reports to be Disclosed:</b>			
<input type="checkbox"/> Emergency Department Records	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Laboratory Reports	
<input type="checkbox"/> Discharge Information	<input type="checkbox"/> Therapy Notes	<input type="checkbox"/> Pathology Reports	
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Plan of Care	<input type="checkbox"/> Radiology Reports	
<input type="checkbox"/> Consults	<input type="checkbox"/> Operative/ Procedure Reports	<input type="checkbox"/> Other: _____	
<b>Purpose of Disclosure:</b> <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> Legal Reasons <input type="checkbox"/> Personal <input type="checkbox"/> Other:			
<b>Release Information From:</b>			
<input type="checkbox"/> Ohio State University Wexner Medical Center	<input type="checkbox"/> Dodd Hall	<input type="checkbox"/> OSUP Clinic (please specify): _____	
<input type="checkbox"/> Ross Heart Hospital	<input type="checkbox"/> James Cancer Hospital		
<input type="checkbox"/> OSU Harding Hospital	<input type="checkbox"/> University Hospital East	<input type="checkbox"/> Other (please specify): _____	
<b>Release Information To:</b> <input type="checkbox"/> Other (specify recipient and complete address below)	<b>Release Information To:</b> <input type="checkbox"/> Ohio State University Physicians, Inc. (specify provider)		
(Name)	(Name)		
(Address)	(Address)		
(Phone)	(Phone)		
<p>Per Ohio Revised Code 3701.741, <b>you may be charged a fee for copies of medical records.</b> If you have questions about an invoice you have received, please contact CIOX Health at 1-800-367-1500. CIOX Health is a business associate of Ohio State University Physicians, Inc. I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/ or AIDS (Acquired Immunodeficiency Syndrome), and /or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of audio, photo or video has been designated above, if applicable. <u>A separate authorization is required for the release of psychotherapy notes.</u> I expressly consent to the release of information designated above. This authorization is valid for <b>365</b> days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. <b>The revocation of this authorization is effective except as indicated in The Ohio State University Health System's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA.</b> I understand that Ohio State University Physicians cannot condition my treatment or payment for health care on this Authorization unless treatment is research- related or the care was provided solely to provide information for a third party.</p> <p>For records covered by 42 CFR Part 2: <b>I understand that my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse patient records, and this notice accompanies a disclosure of such information.</b> This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.</p>			
Signature of the Patient or Person Authorized to Consent			Date Signed
Relationship if not the Patient			
Witness (optional)			Date Signed
Submit requests to the following:		<b>*Please write in your home address and email address:</b>	
Ohio State University Physicians, Inc. ATTN: CIOX 700 Ackerman Road, Ste. 6106 Columbus, Ohio 43202		Home Address _____ _____ _____	
		Email Address _____	