THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

**The Ohio State University Wexner Medical Center**
**Arthur G. James Cancer Hospital & Richard J. Solove Research Institute**
**Wexner Medical Center Ambulatory Surgery Center**
Medical Information Management
N110 Doan Hall
410 W 10th Ave
Columbus, Ohio 43210

**East Hospital**
Medical Information Management
181 Taylor Ave, W113
Columbus, Ohio 43203

**Phone:** (614) 293-8657

# INSTRUCTIONS

## All sections must be completed in their entirety.

1. **Patient Information**: Complete the entire section to clearly and legibly identify patient - entire patient name (and any previous names), date of birth, phone number, and address.

2. **Dates of Service to Release**: This can be a specific date or a date range. For example, July 15, 2023 or June 2020 - Feb 2023. Future dates of service cannot be requested. For example, if you complete this form on June 1, 2023, you may not authorize the release of progress notes from an appointment that is scheduled on June 30, 2023.

3. **Specific Reports to be Disclosed**: Be specific about the information requested to be released. For example, types of notes or the name of the practitioner, etc.

4. **Purpose of Disclosure**: Indicate the reason for release. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (as appropriate).

5. **Release Information From**: If your requested records were documented at a particular Ohio State facility, please check the box for this location. If uncertain about the location, select all box locations.

6. **Release Information To**: Identify the full name/organization, address, phone number, and fax number of the recipient. Please allow 10 business days for processing.

7. **Rights/Signature**: A wet ink signature and date on the form or an eSignature (e.g., Adobe) with a date & time stamp are required.

| Patient Name (First, Middle, Last) | Date of Birth: ___/___/_____ | Last 4 digits of Patient's Social Security Number: | Telephone Number: ( ) |
|---|---|---|---|

**Patient's Address**

**Dates of Service to Release** (From): _____ (To): _____

**Specific Reports to be Disclosed:**

- ❑ Emergency Department Records
- ❑ Discharge Information
- ❑ History and Physical Exam
- ❑ Consults / Assessment
- ❑ Progress Notes
- ❑ Therapy Notes
- ❑ Plan of Care
- ❑ Operative / Procedure Reports
- ❑ Laboratory Reports
- ❑ Pathology Reports
- ❑ Radiology Reports
- ❑ Other:_____

**Purpose of Disclosure:** ❑ Medical Treatment ❑ Disability ❑ Insurance ❑ Legal Reasons ❑ Personal ❑ Other:

**Release Information From:**

- ❑ James Cancer Hospital and Solove Research Institute
- ❑ Ohio State University Wexner Medical Center
- ❑ Brain and Spine Hospital
- ❑ Dodd Hall
- ❑ East Hospital
- ❑ OSU Harding
- ❑ Other (Specify) _____
- ❑ Ross Heart Hospital
- ❑ University Hospital

**Release Information To:** ❑ Other (specify recipient and complete address below)

_____
(Name)

_____
(Address)

_____

_____
(Phone) (Fax)

_____
(Patient's email)

**Release Information To:** ❑ The Ohio State University Wexner Medical Center (specify provider) ❑ James Cancer Hospital and Solove Research Institute (specify provider)

_____

_____

_____

_____

Based on regulatory requirements, a fee may be charged for copies of medical records. 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 The Ohio State University Wexner Medical Center and James Cancer Hospital and Solove Research Institute.

I give the facility as indicated above and its employees and business associates, CIOX, permission to release my medical record, or parts of my record, as noted above and as defined in the designated record set. I understand that the information released may include treatment for physical and mental illness, alcohol or drug use, AIDS (Acquired Immunodeficiency Syndrome) or HIV testing. I know I need to sign a separate form to release any notes related to psychotherapy. This form is valid for one year unless I give written notice prior to the release of the information, as stated in the Notice of Privacy Practices.

The information released as a result of this form may be re-disclosed by the recipient and may no longer be protected by federal or state privacy rules, such as HIPAA.

I understand that treatment or payment for the care I have received at OSUWMC is not dependent on my signing this release, unless treatment is for research or the care was given to provide information to a third party.

If I am requesting records related to substance use disorder, federal law prohibits further release of my information without my written consent and requires an additional specific form to be completed before the records are provided.

_____ _____
Signature of the Patient or Person Authorized to Consent — Date Signed

_____
Relationship if not the Patient

_____ _____
Witness (optional) — Date Signed

Submit requests to one of the following:

The Ohio State University Wexner Medical Center
Medical Information Management
110 Doan Hall, 410 West 10th Avenue
Columbus, Ohio 43210-1228
Phone: (614) 293-8657

East Hospital
Medical Information Management W113
181 Taylor Avenue
Columbus, Ohio 43203 - 1779
Phone: (614) 257-2544

The James Cancer Hospital and Solove Research Institute
1st Floor James Cancer Hospital
James A061
460 West 10th Ave
Columbus, OH 43210 - 2500
Phone: (614) 293-8657

*MS0001*

❑ **THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER**

❑ **JAMES CANCER HOSPITAL AND SOLOVE RESEARCH INSTITUTE**

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MC040184 (11/19)

**Patient Name:**

**Medical Record Number:**

**Date of Birth:**