DEPARTMENT OF MEDICAL INFORMATION MANAGEMENT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Ohio State University Medical Center
Medical Information Management
Doan 140
410 West 10th Avenue
Columbus, OH 43210-1228
Phone: (614) 293-8657

University Hospital East
Medical Information Management
TG 137
1492 East Broad Street
Columbus, OH 43205
Phone: (614) 257-3191

Medical Record Number:_____
For Office Use Only

Patient Name:_____ **Date of Birth:**_____/_____/_____

Last 4 Digits of the Social Security Number:_____ **Telephone Number:**_____

I Authorize (check appropriate box):
❑ University Hospital ❑ Ross Heart Hospital ❑ OSU/Harding Hospital ❑ Dodd Hall ❑ James Cancer Hospital
❑ University Hospital East ❑ Clinic ❑ Other (please specify):_____

To Release Medical Information To (check appropriate box):
❑ Other Name:_____
Address:_____
_____
_____

❑ The Ohio State University Medical Center
Please specify physician or department and address:
_____
_____

Purpose of Disclosure: ❑ Medical Treatment ❑ Disability ❑ Insurance ❑ Legal Reasons ❑ Personal ❑ Other:_____
Dates of Service: _____

Specific Reports To Be Disclosed:

❑ Emergency Department Reports	❑ Operative Reports	❑ Assessment
❑ Discharge Summary	❑ Physical/Occupational Therapy Notes	❑ Treatment Plan
❑ Laboratory Reports	❑ Pathology Reports	❑ Progress Notes(May Include Social Work Notes)
❑ History & Physical	❑ Radiology Reports	❑ Admission Note
❑ Social Work Notes	❑ Other:_____	

Per Ohio Revised Code 3701.741, you may be charged a fee for copies of medical records. If you have questions about copying fees please contact HealthPort at 1-800-367-1500.

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. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for 365 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.

The revocation of this authorization is effective except as indicated in 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. I understand that Ohio State University Medical Center cannot condition my treatment or payment for health care on this Authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

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

X_____
Relationship, if not the patient

X_____ _____
Witness (Optional) — Date Signed

For records covered by 42 CFR Part 2: 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.

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