

FOR OFFICE USE ONLY

FORM RECEIVED: TRANSPLANT #: PRA:
RECIPIENT'S MRN: RECIPIENT'S BLOOD TYPE:
RECIPIENT'S DISEASE:
RECIPIENT'S STATUS: TRANSFUSION HISTORY:

Please complete all sections and submit this form along with a copy of your blood type to the Pre-Transplant Office at the Ohio State Comprehensive Transplant Center.

INFORMATION ABOUT YOUR RECIPIENT

Recipient's name to whom you wish to direct your organ donation:
Recipient's Date of Birth: Your relationship to the Recipient:
Is your Recipient a patient at: Ohio State Wexner Medical Center Nationwide Children's Hospital

YOUR PERSONAL INFORMATION

Your Legal Name: **Date:**
Preferred Name (if applicable): Maiden Name:
Social Security Number: Date of Birth: Age:
Blood Type: A B AB O I have attached a copy of my blood type:
Which organ do you wish to donate? Kidney Liver **OFFICE USE ONLY – MRN:**
Sex: Male Female Height: Weight: **OFFICE USE ONLY – BMI:**
Country of Birth: Citizenship: Race/Ethnicity:
Street Address:
City: State: Zip:
Provide all applicable phone numbers, check the primary number:
 Home Phone: Cell Phone: Work Phone:
Email Address: Marital Status:
Primary Doctor: Primary Care Phone:
With whom may we share appointments and health information?

Legal Name:

Date:

DONATION INTEREST

If considering kidney donation , are you interested in Kidney Paired Exchange with your recipient if you are not compatible match?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you discussed your wish to donate with the intended recipient?.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you discussed your wish to donate with your family / friends?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Why do you wish to donate?		

MEDICAL HISTORY

These questions are used to gather important information about your health and lifestyle that might impact on your potential to become a living donor. This information will be used by the health care professionals on our team to determine your overall well-being. All information on this questionnaire is kept strictly confidential.

GENERAL HEALTH		
1.	Have you ever had any abdominal surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what type, when?	
	• Name of Hospital:	
2.	Have you ever had any other surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what type, when?	
	• Name of Hospital:	
3.	Did you have any problems after surgery/anesthetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what were the problems?	
4.	Have you had any hospitalization for other reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when and why?	
	• Name of Hospital:	
5.	Do you routinely take any medications (including prescriptions, over the counter, vitamins and herbal supplements)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, list:	
6.	Do you have allergies (drug or food)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, to what?	
	• If yes, what type of reaction and symptoms do you have?	
	• If yes, do you carry an EpiPen?	
7.	Do have allergies to iodine, contrast dye, latex, shellfish?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Legal Name:

Date:

8.	Do you have Arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what is your current treatment?	<input type="text"/>	
9.	Do you currently smoke or have you ever smoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what (cigarettes, pipe, cigars)?	<input type="text"/>	
	• How many per day?	<input type="text"/>	For How Long: <input type="text"/> Years? <input type="text"/>
	• If you have quit, when did you quit?	<input type="text"/>	
10.	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• How many drinks per week?	<input type="text"/>	(1 drink = 1 bottle of beer, 1 glass of wine or 1-½ oz of spirits)
	• For how long?	<input type="text"/>	
	• Have you ever had treatment for alcohol abuse / dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Have you had any recent unexplained weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, explain:	<input type="text"/>	

LIVER HEALTH

12.	Have you ever had jaundice (yellow skin)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?	<input type="text"/>	
13.	Have you ever had a liver problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what type, when?	<input type="text"/>	
14.	Is there a family history of liver problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what?	<input type="text"/>	

CANCER HISTORY

15.	Have you had cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, type?	<input type="text"/>	
	• When?	<input type="text"/>	
	• Treatment: <input type="checkbox"/> Radiation <input type="checkbox"/> Chemo <input type="checkbox"/> Surgery <input type="checkbox"/> Other:	<input type="text"/>	
16.	Do you have a family history of cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, who?	<input type="text"/>	
	• What type of cancer?	<input type="text"/>	

INFECTION RISKS:

17.	Have you ever received a blood transfusion or other blood product?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, type?	<input type="text"/>	
	• When?	<input type="text"/>	
	• Will you accept blood products if necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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18.	In the last 12 months have you had a tattoo, ear piercing or body piercing in which sterile procedures were not used (e.g. contaminated instruments and/or ink were used or shared instruments that had not been sterilized between uses were used)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what?	
	• When?	
19.	Do you have a chronic infection of any type?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what type, when?	
20.	Do you or have you ever had Methicillin-Resistant Staphylococcus Aureus (MRSA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Do you have or have you ever had any history of hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what type, when?	
22.	Do you have or have you ever had any history of syphilis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what type, when?	
23.	In the past 12 months have you had close contact with another person having hepatitis (e.g. living in the same household, where sharing of kitchen and bathroom facilities occurs regularly?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.	Do you currently use or have you ever used nonmedical or recreational/ street drugs (ingested, inhaled, subcutaneous, intramuscular or intravenous drugs e.g. LSD, marijuana, hash, cocaine)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what and when?	
	• Have you ever had treatment for this?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what treatment and when?	
25.	Have you been treated for any infection in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what?	
	• When?	
26.	Have you ever tested positive for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when?	
27.	Have you had any vaccinations in the last 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what type, when?	
28.	Have you been vaccinated for Hepatitis B?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when or at what age?	
29.	Have you ever been suspected of having or been diagnosed with West Nile Virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when?	
30.	Have you ever been diagnosed with Valley Fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when?	
31.	Within the last 6 months have you traveled to southwest parts of the U.S. or anywhere outside of the U.S.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, where and when?	

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32.	TB SCREENING:	
	• Have you had close contact with a person known to have tuberculosis (TB)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when? <input style="width: 150px;" type="text"/>	
	• Have you ever had a positive TB skin test yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, treatment? <input style="width: 150px;" type="text"/>	
	• Were you born or have lived outside of the U.S.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what country? <input style="width: 150px;" type="text"/>	
	• Have you recently traveled outside the U.S.?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, which country(s)? Dates? <input style="width: 150px;" type="text"/>	
	• Have you lived or worked in a homeless shelter/correctional facility/nursing home/hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, which location(s)? Dates? <input style="width: 150px;" type="text"/>	
	• Do you have a history of intravenous (IV) drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when? <input style="width: 150px;" type="text"/>	
	• Have you had an abnormal chest X-ray or been told you have scars on your lungs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when? <input style="width: 150px;" type="text"/>	
NEUROLOGICAL/PSYCHOLOGICAL		
33.	Do you have a seizure disorder/epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• Please provide details: <input style="width: 150px;" type="text"/>	
34.	Have you ever had a stroke/transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes when? <input style="width: 150px;" type="text"/>	
35.	Have you been diagnosed with or been investigated for any degenerative neurological diseases such as dementia, Alzheimer's, brain tumors, Parkinson's disease, Lou Gehrig's, Multiple Sclerosis (MS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what and when? <input style="width: 150px;" type="text"/>	
36.	Have you ever had treatment for depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when? <input style="width: 150px;" type="text"/>	
	• Treatment: <input style="width: 150px;" type="text"/>	
37.	Do you have a mental health provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, provider's name? <input style="width: 150px;" type="text"/>	
	• Provider's phone number: <input style="width: 150px;" type="text"/>	
38.	Have you ever had treatment for a psychiatric problem, suicidal thoughts or attempts, depression, anxiety, PTSD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, when? <input style="width: 150px;" type="text"/>	
	• Treatment: <input style="width: 150px;" type="text"/>	

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CARDIOVASCULAR

39.	Do you have a history of heart disease or chest pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, elaborate:		
40.	Have you ever had high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, date of diagnosis?		
	• Type of treatment:		
	• Length of treatment:		
41.	Have you had a heart attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?		
42.	Have you ever had rheumatic fever, or been told you have a heart murmur or mitral valve prolapse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?		
43.	Have you ever had palpitations or been told that you have a heart arrhythmia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?		
44.	Do you have a pacemaker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
45.	Have you ever had a stress test or heart catheterization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEMATOLOGY / BLOOD

46.	Do you and/or a family member have hemophilia or a clotting problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what?		
47.	Do you have a history of anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, explain?		
48.	Have you or any of your family members had a problem with excessive bleeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?		
49.	Have you had excessive bleeding with any surgery or dental extractions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?		
50.	Have you and/or a family member ever had a blood clot in your lungs or legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, who?	Relationship:	
	• Location:	Date of Diagnosis:	
	• Treatment:		

RESPIRATORY

51.	Have you ever had any lung disease such as asthma or emphysema?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what?		
	• When?		
	• Any treatment?		
52.	Have you been treated for pneumonia in the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Legal Name:

Date:

53.	Do you routinely use any inhalers or take medications to help your breathing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what?			
54.	Do you have sleep apnea or use a CPAP machine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, describe:			
GASTROINTESTINAL				
55.	Do you have any stomach or intestinal problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what?			
56.	Have you ever had gallbladder problems or gallstones?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?			
57.	Have you ever had a colonoscopy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, when?			
	• Where was the procedure performed?			
GENITOURINARY				
58.	Have you ever had problems with your kidneys (such as infections or stones)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what type and when?			
59.	Have you ever had any problems with your bladder (such as infections, incontinence, difficulty voiding or blood in your urine)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, please describe:			
	• When?			
60.	FOR MALES ONLY:			
	• Do you have any problems related to an enlarged prostate?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	• If yes, what?			
	61.	FOR FEMALES ONLY:		
• Date of last menstrual period:				
• Date of last PAP smear:				
• Date of last mammogram:				
• Have you ever had a gynecologic problem?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• If yes, what?				
• Have you had any pregnancies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• If yes, did you experience any problems with your pregnancies or deliveries (such as high blood pressure, toxemia or gestational diabetes/high blood sugar)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• If yes, please describe?				
• List ages of your children:				
• Are you currently trying to become pregnant or do you have plans for future pregnancies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Legal Name:

Date:

ENDOCRINE

62.	Do you have diabetes?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, type?		
	• Onset?		
63.	Do you have a family history of diabetes or high blood sugar?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, who?		
64.	Have you ever had increased blood sugars?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, please describe:		
65.	Have you ever been diagnosed with thyroid disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	• If yes, what and when?		
	• Treatment:		
66.	Does your family have a history of any serious health issues?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	(i.e. heart disease, stroke, kidney disease, liver disease, lupus)		
	• If yes, please outline:		

SOCIAL

67.	Are you the sole wage earner in your household?		<input type="checkbox"/> Yes <input type="checkbox"/> No
68.	Donating an organ requires time off work to recover. Are you able to take time off work? (4 to 6 weeks for kidney donation; 8 to 12 weeks for portion of liver donation)		<input type="checkbox"/> Yes <input type="checkbox"/> No
69.	Employer:		
	Occupation:		Highest Education Level: <input type="text"/>

– We are required to ask the following questions to meet government regulations.
– We acknowledge that these are of a sensitive nature and all information will be kept strictly confidential.
– If you have any questions, please speak with a member of the living donor team.

70.	In the past 12 months, have you been exposed to known or suspected HIV, Hepatitis B and/or Hepatitis C infected blood through sexual contact, skin punctures, or through contact with an open wound, non-intact skin or mucous membrane?	<input type="checkbox"/> Yes <input type="checkbox"/> No
71.	In the past 12 months, have you been diagnosed or treated for syphilis, chlamydia or gonorrhea? ..	<input type="checkbox"/> Yes <input type="checkbox"/> No
72.	In the past 12 months, have you ever had sex in exchange for money or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
73.	In the past 12 months, did any of your sexual partners have sex in exchange for money or drugs? ...	<input type="checkbox"/> Yes <input type="checkbox"/> No
74.	In the past 12 months, did you have sex with any person known or suspected to have hepatitis or HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
75.	In the past 12 months have you or any sexual partner used a needle to inject drugs into your veins, muscles or under the skin, for non-medical use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
76.	In the past 12 months have you been in juvenile detention, lock up, jail or prison for more than 72 consecutive hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
77.	FOR FEMALES: In the past 12 months have you had sex with a man who had sex with another man?	<input type="checkbox"/> Yes <input type="checkbox"/> No
78.	FOR MALES: In the past 12 months have you had sex with another man?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Legal Name:

Date:

OTHER		
79.	Is there any other information that we should know? • If yes, what? <input style="width: 500px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
80.	Having answered all questions about medical conditions and behavioral risk factors is there any reason why you think you should not be an organ donor? <i>You do not have to give an explanation for your answer.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HISTORY			
Relation	NAME	PRESENT AGE (OR AGE AT DEATH)	- IF LIVING: HEALTH STATUS (<i>GOOD, FAIR POOR</i>) - IF DECEASED: CAUSE OF DEATH
Father:			
Mother:			
Sibling 1:			
Sibling 2:			
Sibling 3:			
Sibling 4:			
Sibling 5:			

Legal Name:

Date:

FORM APPROVAL AND VERIFICATION

I have answered the questions for this Living Donor Assessment Form from Ohio State's Comprehensive Transplant Center truthfully and to the best of my ability.

Legal Name of Potential Donor

Signature of Potential Donor

Date

FOR OFFICE USE ONLY

BASED ON THE REVIEW OF THE HEALTH HISTORY, THIS POTENTIAL DONOR IS:

SUITABLE FOR ASSESSMENT

NOT SUITABLE FOR ASSESSMENT

REASON:

COMMENTS:

REVIEWED BY:

SIGNATURE:

DATE:

If you know your blood type, please include a
COPY OF YOUR AMERICAN RED CROSS BLOOD TYPE CARD
with this form and return them to:

The Ohio State University Wexner Medical Center
Comprehensive Transplant Center | Pre-Transplant Office

300 W. 10th Ave., 11th Floor

Columbus, OH 43212

614-293-6724 or 800-293-8965

Fax: 614-293-6710

Legal Name:

Date:

PRE-EVALUATION CONSENT FORM

I acknowledge that various tests will need to be performed prior to scheduling a formal donor evaluation.

Such tests may include:

- Blood Typing (ABO)
- HLA / Tissue Typing
- Crossmatch (compatibility test)
- Blood Chemistries
- Glucose Tolerance Testing
- Urinalysis and 24-Hour Urine Chemistries
- Ambulatory Blood Pressure Monitoring
- Diagnostic Imaging by ultrasound or X-ray

I hereby voluntarily consent to having all such tests performed.

Legal Name of Potential Donor:

Potential Donor Signature:

Date:



Authorization to Release Medical Information

Patient Name (First, Middle, Last)	Date of Birth: ____/____/____	Last 4 digits of Patient's Social Security Number:	Telephone Number: ()
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Dates of Service to Release (From): _____ (To): _____

Specific Reports to be Disclosed:

<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: _____

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

Release Information From:

<input type="checkbox"/> Ohio State University Wexner Medical Center	<input type="checkbox"/> Dodd Hall	<input type="checkbox"/> OSU Clinic (please specify): _____
<input type="checkbox"/> Ross Heart Hospital	<input type="checkbox"/> James Cancer Hospital	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> OSU Harding Hospital	<input type="checkbox"/> University Hospital East	

<p>Release Information To: <input type="checkbox"/> Other (specify recipient and complete address below)</p> <p>_____ (Name)</p> <p>_____ (Address)</p> <p>_____ (Phone)</p>	<p>Release Information To: <input type="checkbox"/> The Ohio State University Wexner Medical Center (specify provider)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Per Ohio Revised Code 3701.741, **you may be charged a fee 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.

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 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.*** I understand that Ohio State University Wexner Medical Center 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.

For records covered by 42 CFR Part 2: **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.** 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.

Signature of the Patient or Person Authorized to Consent	Date Signed
Relationship if not the Patient	
Witness (optional)	Date Signed

<p>Submit requests to one of the following:</p> <p style="padding-left: 40px;">The Ohio State University Wexner Medical Center Medical Information Management N113 Doan Hall 410 West 10th Avenue Columbus, Ohio 43210-1228 Phone: (614) 293-8657</p>	<p style="padding-left: 40px;">University Hospital East Medical Information Management W113 181 Taylor Avenue Columbus, Ohio 43203 Phone: (614) 257-2544</p>
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