Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Physician: _____

Address: _____ Telephone: _____

Information Requested

Entire Medical Record: ☐ Yes ☐ No If no, please specify documents or dates of service: _____

_____

I would like copies of my health information indicated in the section above sent:

From: _____ To: _____

_____ _____

_____ _____

_____ _____

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statue and Ohio Department of Public Health rules, which include venereal disease, Tuberculosis, Hepatitis A,B,C, Human Immunodeficiency Virus (HIV), HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS), and AIDS related complex (ARC) and _____(specify).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, part 2.
- Mental health treatments records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.

Purpose of Disclosure: (check one)

☐ Attorney / Legal ☐ Continued Patient Care ☐ Insurance ☐ Personal Use ☐ Disability

☐ Other: _____

Reason for Transferring Care:_____

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization, or person. I further understand that correspondence, patient discharge instructions and records from healthcare providers other than Huey & Weprin, Ob/Gyn, Inc.. will not be released unless specifically requested above.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it. This authorization will expire 60 days from the date signed.

I understand that health information that is released under this authorization may be subject to re-disclosure by the recipient, and the privacy of my health information may no longer be protected by the law. I also understand that the doctor, health care provider, or health plan from whom my medical information is requested in this authorization, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

A faxed copy of this authorization shall have the same effect as the original.

A **fee** for copying records is due upon request or receipt if records are copied for the patient.

_____ _____ _____

Signature of Patient or Legal Representative | Date | Relationship to Patient

_____ _____

Witness | Date | ID Checked: _____