PROMEDICA

# AUTHORIZATION TO RELEASE PATIENT INFORMATION

**Patient Name:** _____ **SS # (Last 4 digits):** _____

**Patient Address:** _____ **Date of Birth:** _____

_____ **Phone Number:** _____

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**1. I am the patient listed above or the legally authorized representative of the patient listed above. I request that protected health information be released :**

| **From:** Physician/Hospital authorized to DISCLOSE information | **To:** Person/Physician/Organization authorized to RECEIVE the information |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**2. Information should be on: and delivered via:**

| ***Electronic Delivery*** | ***CD*** | ***Paper*** |
|---|---|---|
| ☐ Secure Email | ☐ Mail to above address | ☐ Mail to above address |
| ☐ On-site Review | ☐ Picked-up by: _____ | ☐ Picked-up by: _____ |
| ☐ ProMedica MyChart | (ID is required for picked- up) | (ID is required for picked- up) |
| ☐ Include Proxy(ies) Name(s): | | ☐ Fax: _____ |
| _____ | | |
| _____ | | |

**3. Specific dates of service to be released:** _____

**4. Records to be released:** *(check option below)*

☐ Physician Office Pertinent Transfer Package (standard two years of information)

☐ Hospital Pertinent Package (Discharge Summary, H&P, Operative Report, Consults, Labs, Rads and diagnostic testing)

☐ Progress Notes ☐ Laboratory Results ☐ Radiology Results ☐ Billing Statements ☐Other: _____

☐ Operative Notes ☐ Emergency Record ☐ Immunization Record ☐ Diagnostic testing: _____

☐ Discharge Summary ☐ Alcohol and/or Drug abuse Treatment Program

☐ Psychiatric Treatment Program *(Psychotherapy notes are not considered part of the Psychiatric Program designated record set.)*

**5. Purpose of Release/Disclosure: (Complete Only for Third Party Requestor – Not Applicable for Patient/Patient Representative Requests)**

☐ Transfer- Physician office ☐ Substantiation of payment claims/Insurance ☐ Legal Use ☐ Personal Use

☐ Continuation of medical care ☐ Lab Monitoring ☐ Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, for Ohio entities this authorization will expire in 1 year, for Michigan entities this authorization will expire in sixty (60) days. If this authorization is for a use or disclosure of PHI for research, this authorization will expire at the end of the research study.
6. For Addiction Treatment and/or Behavioral Health Services Records: "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 C.F.R. 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". OAC 5122-27-06.

**Signature of Patient or Legally Authorized Representative:** X_____ **Date:** X_____

**Relationship to Patient:** _____ **Witness:** _____

**If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)**

☐ Parent ☐ Durable Power of Attorney for Health Care ☐ Legally Authorized Representative

☐ Personal Representative of the Estate ☐ Other (specify and attach proof) _____

Send COMPLETED form to System HIM via email phs.him.roi@promedica.org or fax 419-479-6919. Please be aware that information sent via email is not secure and could be misdirected or intercepted in transmission.