EMERALD OBGYN

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# Authorization for Release of Protected Health Information

Patient Name:_____ Date of Birth:_____

Social Security Number:_____ Telephone:_____

Address:_____

**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: (Who is sending records)_____ TO: (Who is receiving records)_____

_____ _____

_____ _____

_____ _____

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, and C, Human Immunodeficiency Virus (HIV), and HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS), and AIDS related complex (ARC).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, part 2.
- Mental health treatment records, psychological services and social services information including communications made by me to a social worker, therapist, or psychologist.
- Genetic testing and information.

**Purpose of Disclosure: (check one)**

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

☐ Other: _____

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 health care providers other than Emerald Obstetrics and Gynecology 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 30 days from the date signed.

I understand that health information 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 law. I also understand that the doctor, health care provider, or health plan from whom my medical information is requested in this authorization, many 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 another physician's office or hospital, there is no charge.

_____ _____ _____

Signature of Patient or Legal Representative Date Relationship to Patient

_____ _____

Witness Date ID Checked:_____