HealthSource of Ohio

Patient's Name: _____ **Chart No.**_____

AUTHORIZATION FOR RELEASE/EXCHANGE OF MEDICAL/DENTAL/VISION/BEHAVIORAL HEALTH INFORMATION

HealthSource of Ohio will not require you to sign this form in order to receive treatment, payment, or eligibility for benefits, unless otherwise specifically permitted by the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules. *Records released pursuant to this authorization may include information concerning testing, diagnosis, or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault (OAC 5160-1-32.1)*

Please complete each step of the form.

STEP 1 Who is the medical, dental, vision or behavioral health information about? ***Please Print!***

Patient's Legal Name: _____ Date of Birth: _____

Name at the Time, if Different: _____ SS: _____-_____-_____

Current Address: _____
Street

_____
City State Zip

STEP 2 Who has the records now?
Doctor or Facility:
_____

Address:
_____

_____

STEP 3 Who do you want to release the records to?
Name:
_____

Address:
_____

_____

STEP 4 What information do you want released? ***Check one or more.***

The following information will be disclosed (please check):	☐Problem List ☐Medication List ☐Procedures ☐Growth Charts ☐Health Maintenance Sheet ☐Immunization Records ☐Assessment and Treatment Plan	Prenatal Records GYN Screen Dental Records Dental X-Rays Care Team Members Clinical Notes Smoking Status Allergies and Intolerances Behavioral Health Other _____	TEST RESULTS: ☐Laboratory Reports ☐X-Rays ☐EKGs ☐Other ☐ PROGRESS NOTES:

Include all checked items from _____ to _____
(date) (date)

over, please ➡

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STEP 5 Information is to be used for: ***Check One.***

☐1. At the request of the individual (self/personal) ☐To inspect at HealthSource of Ohio during normal business hours ☐To provide me photocopy of my records ☐To provide me digital copy of my records ☐2. Continuing medical, dental, vision, or behavioral health care ☐3. Claim evaluation and presentation (insurance review) ☐4. Disability	
☐5. Damage or legal presentation ☐6. For transfer of care ☐7. For marketing or research purposes ☐8. Other (specify) _____	Office Review Required (5-8) ☐ OK to send

STEP 6 Permission and signature:

I authorize the use and disclosure of the individually identifiable health information requested above. I certify that I am making this request voluntarily, and that the information above is accurate to the best of my knowledge. This release of information is governed by the policies stated in the HealthSource of Ohio Privacy Notice. Please request a copy of our Privacy Notice if you wish to review our policies.

Expiration Date: This is a one-time release which will expire within forty-five (45) days from the date of my signature. My medical records may not be released again to those listed above without my further written consent. However, if the release is for research purposes, the expiration date will be the end of the research study, and if the release is to create or maintain a research database or repository, there will be no expiration date.

Potential for Redisclosure: In some cases, the information that will be released may be later re-disclosed, and then no longer protected under applicable Federal privacy regulations, including the Privacy Rules of the HIPAA. However, such re-disclosure could still be protected under State privacy law.

Right to Terminate or revoke: I understand that I may revoke (take back) this Consent in writing, by delivering written notice to the *Doctor or Facility who I originally authorized to release the information* (See STEP 2 for name and address.) The revocation becomes effective within thirty (30) business days following the date of receipt by the party in STEP 2. Such revocation will NOT cover actions which were permitted by this Consent and already taken by the party in STEP 2 prior to revocation.

STEP 6 - Continued Permission and signature (continued):

You may see and copy the health information requested on this form if you ask. You will be given a copy of this form after you sign it.

X _____ _____

Signature of Patient, Parent, or Legal Guardian **Date Signed**

If not signed by patient, please specify reason: Patient is a minor ☐ years old **OR** cannot sign ☐
because: _____