

UC Center for Reproductive Health

The Christ Hospital Medical Office Building
2123 Auburn Ave., Suite A44
Cincinnati, OH 45219
PH: 513-585-2355 FX: 513-585-3098

UC Health Physicians Office
7700 University Court, Suite 3000
West Chester, OH 45069
PH: 513-585-2355 FX: 513-475-8267

Medical Record Release Authorization for Use and Disclosure of Protected Health Information (PHI)

This Authorization is according to federal Privacy Laws.

Patient Information

Last Name _____ First _____ Middle _____

Maiden Name _____ Address _____

City _____ State _____ Zip _____

SS Number _____ - _____ - _____ Date of Birth ____/____/____

Phone () _____ - _____

I, the above identified person, do hereby authorize the release of my PHI as indicated – Identify individual/group/ entity and list addresses.

From: _____

To: _____

- | | |
|---|--|
| <input type="checkbox"/> Christ Hosp. MOB 2123 Auburn Ave., Suite A-44 Cincinnati, OH 45219 P: (513) 585-2355 F: (513) 585-3098 | <input type="checkbox"/> UC Health Physicians Office 770 University Court Suite 3000 West Chester, OH 45069 P: (513) 475-8266 F: (513) 475-8267 |
|---|--|

I understand that this authorization is voluntary and that it may include information relating to *AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse*. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be redisclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

This authorization covers the following periods of healthcare:

- All Periods of Healthcare
- From ____/____/____ To ____/____/____
- From ____/____/____ To ____/____/____

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

- | | |
|---|---|
| <input type="checkbox"/> Entire Medical Record (does NOT include radiology images, billing records and psychotherapy notes) | |
| <input type="checkbox"/> Office Visits | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Psychotherapy Notes |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Billing Records (itemized statements, EOB, HCFA1500) |
| <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Laboratory Reports | |



This information is being disclosed for the following purposes:

- Legal Reasons
- Continued Care and Treatment
- At the Request of the Patient
- Insurance
- Workman's Compensation
- Personal Use
- Disability

Other (Explanation) _____

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

This authorization will expire in 120 days unless otherwise specified (insert date or specific event) _____

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature _____ Date ____/____/____

If you are signing as a legal representative for an individual, read and sign below:

I, _____, hereby certify and attest that I am the duly authorized legal representative of _____ and that I have the lawful authority regarding the use and or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

Signature

Print Name

Date

YOU SHOULD RECEIVE A COPY OF THIS AUTHORIZATION FORM AFTER SIGNING.

Received By _____ Date Received ____/____/____