The Christ Hospital
CINCINNATI, OH 45219

R3148 REV 09/13

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

TO BE USED: 1) When patient or patient's legal representative requests use or disclosure of PHI; 2) for requests by or to an entity unless exceptions apply; 3) for use and disclosure of PHI for research (when patient has not signed a research informed consent that includes authorization or researcher has not received a waiver by the I.R.B. or privacy board); and 4) when no other exceptions apply.

Protected Health Information ("PHI") under HIPAA is defined as information that is received from, or created or received on behalf of The Christ Hospital and is information about an individual which relates to past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to an patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

PATIENT INFORMATION

Last Name _____ First _____ Middle _____ Maiden _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security No. _____ Phone _____

COPIES SENT FROM/TO

Agency/Hospital	FROM	TO: (Address where you would like your copies to be sent)
Name of Person	The Christ Hospital	
Street Address	2139 Auburn Ave	
City,State,Zip	Cincinnati, OH 45219	

PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

Check box to indicate PHI that may be used or disclosed. On the line provided, please indicate the dates of service for each service type. The following are not the only types of service. Please indicate any additional service types that are not listed under "other".

- ☐ Inpatient_____
- ☐ Emergency Department_____
- ☐ Physical Therapy_____
- ☐ Same Day Surgery_____
- ☐ Outpatient_____
- ☐ Other_____

Pertinent summary documents (*) from the above visits will be sent, unless specified reports are indicated below:

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The following does not constitute every document in a medical record. If you wish to receive a copy of the entire medical record please mark "entire".

- ☐ Face Sheet*
- ☐ History & Physical
- ☐ Consultation Reports*
- ☐ Discharge Summary*
- ☐ Operative Reports*
- ☐ Pathology Reports*
- ☐ Other_____
- ☐ Lab Reports*
- ☐ X-Ray Reports*
- ☐ Diagnostic Images
- ☐ Test Reports*
- ☐ Therapy Reports
- ☐ Emergency Treatment
- ☐ **Entire Medical Record (this will include every page in the Medical Record, i.e. Nursing Notes, Consent Forms, any and all reports, etc)**

REASON NEEDED

Please specify the reason for your request:

- ☐ Medical care
- ☐ Disability
- ☐ At My Request/Personal Reasons
- ☐ Legal Reasons
- ☐ Insurance
- ☐ Other _____

☐ I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

☐ I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to _____

(**fill in entity specific name/address where revocations must be sent).**

☐ I understand that I may refuse to sign this authorization and that 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.

☐ I understand that I will be charged for requesting copies of my medical records and acknowledge that a Christ Hospital representative has discussed the pricing scheme with me.

EXPIRATION

This authorization will expire in 60 days unless otherwise specified (**insert date or specific event)** _____.

☐ I hereby authorize the use of disclosure of my protected health information as described above. I authorize the hospital to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV).

_____ _____

Patient/ Legal Representative* Date/Time

*Reason Patient is unable to sign _____

*Describe scope of authority to act for patient _____

Provide guardianship, executor of estate, power of attorney papers

_____ _____

Witness Signature Date/Time

Retain original copy in Medical Records. Copy to patient or legal representative