ROI Authorization

MEDICAL RECORDS DEPARTMENT

TELEPHONE NUMBER: (513) 298-7750 FAX NUMBER: (513) 298-7765

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 Health Alliance 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 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: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a patient, including birth date, admission date, discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; 3) 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 Number: _____ Phone: _____

COPIES SENT FROM/TO

Agency/Hospital	**From:**	**To:**
Name & Title of Person:	West Chester Medical Center	_____
Street Address:	7700 University Drive	_____
City, State & Zip	West Chester, OH 45069	_____

UC Health
WEST CHESTER HOSPITAL

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Protected Health Information To Be Used or Disclosed

Check box to indicate PHI that may be used or disclosed:

- ☐ Inpatient
- ☐ Emergency Department
- ☐ Physical Therapy
- ☐ Same Day Surgery
- ☐ Outpatient

DATES

Please provide specific dates of service. Requests for "any and all" records may delay the processing of your request.

_____
_____
_____
_____
_____

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

- ☐ Face Sheet*
- ☐ History & Physical
- ☐ Consultation Reports*
- ☐ Discharge Summary*
- ☐ Operative Reports*
- ☐ Pathology Reports*
- ☐ Entire Record
- ☐ Lab Reports*
- ☐ X-Ray Reports*
- ☐ Diagnostic Images
- ☐ Test Reports*
- ☐ Therapy Reports
- ☐ Emergency Treatment
- ☐ Other_____

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 redisclosed 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 Medical Record Department, Release of Information, West Chester Medical Center, 7700 University Drive, West Chester, Ohio 45069.

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.

EXPIRATION

The authorization will expire in 60 days unless otherwise specified as: (insert date or specific event)

_____

I hereby authorize the use of disclosure of may 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

*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

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

MRAUTH