UC Health Physicians Office South
7675 Wellness Way, Suite 315
West Chester, Ohio 45069

UC Health Center for Reproductive Health

The Christ Hospital
2123 Auburn Avenue, Suite A43
Cincinnati, Ohio 45219

P: (513) 475-7600

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: _____

☐ Christ Hosp. MOB
2123 Auburn Ave., Suite A-44
Cincinnati, OH 45219
P: (513) 585-2355
F: (513) 585-3098

☐ UC Health Physicians Office
7675 Wellness Way
West Chester, OH 45069
P: (513) 475-7600
F: (513) 475-7601

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):

- ❑ Entire Medical Record (does NOT include radiology images, billing records and psychotherapy notes)
- ❑ Office Visits
- ❑ Consultation Reports
- ❑ Radiology Reports
- ❑ Radiology Images
- ❑ Laboratory Reports
- ❑ Operative Report
- ❑ Psychotherapy Notes
- ❑ Billing Records (itemized statements, EOB, HCFA1500)
- ❑ Other (please specify)_____

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 _____/_____/_____