CENTRAL OHIO PRIMARY CARE

AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

(Please Complete All Highlighted Sections to Avoid Any Delays in Processing)

Please Print

Patient's Name: _____ **Date of Birth:** _____ **Patient #** _____
Last **First** **Middle** **(M/D/Y)**

Address: _____
Street **City** **State** **Zip**

Phone Number: _____ **E-Mail Address:** _____ **Date(s) of Service:** _____

Purpose of Release:

- □ **Continuity of Care/Treatment**
- □ **Self/Personal Reasons**
- □ **Disability**
- □ **Leaving COPC Practice/Physician *(specify reason below)***
  - □ **My Insurance Coverage Changed**
  - □ **Move/Location Change**
  - □ **Patient Preference**
  - □ **Leaving Specialist**
- □ **Employment Related**
- □ **Provide to Insurance Company**
- □ **Transfer to other COPC practice/physician**
- □ **Research**
- □ **Legal Reasons**
- □ **Other (please specify):** _____

Physician Practice/Organization Authorized to **Release** Information:

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

Person/Physician Practice/Organization Authorized to **Receive** Information**:**

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

Information to be Released – For the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all the documents listed.

□ **Complete Record**	□ **Minimum Documents** (the following will be sent) • **Progress Notes – last 2 years** • **Radiology (if applicable) – last 2 years** • **Lab (if applicable) –last 2 years** • **Other Diagnostic Tests (if applicable)-last 2yrs** • **Cardiovascular (if applicable) – last 2 years** • **Consultations – last 2 years** • **Hospital Records – last 2 years**	□ **Additional Documents** (comprised of Minimum Documents plus the following selected items): □ **Physician Orders** □ **Nurses Notes** □ **Graphics** □ **Physical Therapy** □ **Medication Lists** □ **Other/Misc:** _____

Method of Release:

□ **Mail** □ **Fax** □ **Email** □ **Other (please specify):** _____

Expiration: This authorization for release of protected health information for the date(s) of service indicated is effective until _____ or for a maximum of one year from the date signed below.

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that COPC has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to the COPC Health Information Department, 655 Africa Road, Westerville, Ohio 43082.

Redisclosure: I understand that the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by subpart 45 CFR 164.508 (c).

Fees: According to Ohio Revised Code, there is a per page fee for records. This fee will depend on the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.

COPC does not condition treatment, payment enrollment or eligibility for benefits on the signing of this authorization.

I hereby authorize the release of my health information from the Practice/Organization named above to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

Form Revision: 11/21/13, 2/26/15, 6/6/2018, 3/30/2022, 10/27/23, 8/22/24