



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 (minimum document set)
 - Employment Related
 - Other (please specify): _____
 - Leaving Practice/Change of Doctor (minimum document set)
 - Disability (minimum document set)
 - Research
 - Insurance
 - Legal Reasons

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

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

Name: _____

Name: _____

Address: _____

Address: _____

City, State & Zip: _____

City, State & Zip: _____

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

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.

- | | | |
|---|---|--|
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Minimum Documents (the following will be sent) <ul style="list-style-type: none"> • 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 | <input type="checkbox"/> Additional Documents (comprised of Minimum Documents plus the following selected items): <ul style="list-style-type: none"> <input type="checkbox"/> Physician Orders <input type="checkbox"/> Nurses Notes <input type="checkbox"/> Graphics <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Medication Lists <input type="checkbox"/> Other/Misc: _____ |
|---|---|--|

Method of Release:

- Mail Fax 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: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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).