THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Wexner Medical Center
Arthur G. James Cancer Hospital & Richard J. Solove Research Institute
Wexner Medical Center Ambulatory Surgery Center
Medical Information Management
N110 Doan Hall
410 W 10th Ave
Columbus, Ohio 43210

East Hospital
Medical Information Management
181 Taylor Ave, W113
Columbus, Ohio 43203

Phone: (614) 293-8657

Re: Deceased Patient Medical Records Requests

To obtain a deceased patient's medical records, you will need:

1. Executor of the Estate Proof
    a. If this does not exist, the attached affidavit must be completed and notarized with a copy of the death certificate.
2. **And** a completed Authorization to Release Medical Information form.

Submit the above documents to Medical Information Management either in person or via mail:

MIM Operations
110 Doan Hall
410 W 10th Avenue
Columbus, Ohio, 43210

Questions, please call (614) 293-8657.

Regards,

Release of information
Medical Information Management, Operations

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Affidavit for Release of Medical Records

Patient Name: _____

Date of Birth: _____

SSN: _____

Deceased Date: _____

Today's Date: _____

Dear Ohio State University Wexner Medical Center:

I am requesting copies of medical records and am providing the following information to comply with your request:

- There are no other relatives that are rightful heirs to the information.
- No estate exists and I have attempted but was unable to obtain a release from probate court.
- I will provide picture identification upon request and at the time of delivery.

Sincerely,

_____ _____

Name of Requestor Relationship to Decedent

Sworn to and subscribed in my presence this _____ day of _____, 20___.

_____

Notary Public

Patient Name (First, Middle, Last)	Date of Birth: ___/___/_____	Last 4 digits of Patient's Social Security Number:	Telephone Number: ( )

Patient's Address

Dates of Service to Release (From): _____ (To): _____

Specific Reports to be Disclosed:

❑ Emergency Department Records	❑ Progress Notes	❑ Laboratory Reports
❑ Discharge Information	❑ Therapy Notes	❑ Pathology Reports
❑ History and Physical Exam	❑ Plan of Care	❑ Radiology Reports
❑ Consults/Assessment	❑ Operative/ Procedure Reports	❑ Other: _____

Purpose of Disclosure: ❑ Medical Treatment ❑ Disability ❑ Insurance ❑ Legal Reasons ❑ Personal ❑ Other:

Release Information From:

❑ James Cancer Hospital and Solove Research Institute

Ohio State University Wexner Medical Center
❑ Brain and Spine Hospital
❑ Dodd Hall
❑ East Hospital
❑ OSU Harding
❑ Other (Specify) _____
❑ Ross Heart Hospital
❑ University Hospital

Release Information To: ❑ Other (specify recipient and complete address below)

_____
(Name)
_____
(Address)
_____
_____
(Phone) (Fax)
_____
(Patient's email)

Release Information To: ❑ The Ohio State University Wexner Medical Center (specify provider) ❑ James Cancer Hospital and Solove Research Institute (specify provider)

_____
_____
_____
_____

Based on regulatory requirements, a fee may be charged for copies of medical records. If you have questions about an invoice you have received, please contact CIOX Health at 1-800-367-1500. CIOX Health is a business associate of The Ohio State University Wexner Medical Center and James Cancer Hospital and Solove Research Institute.

I give the facility as indicated above and its employees and business associates, CIOX, permission to release my medical record, or parts of my record, as noted above and as defined in the designated record set. I understand that the information released may include treatment for physical and mental illness, alcohol or drug use, AIDS (Acquired Immunodeficiency Syndrome) or HIV testing. I know I need to sign a separate form to release any notes related to psychotherapy. This form is valid for one year unless I give written notice prior to the release of the information, as stated in the Notice of Privacy Practices.

The information released as a result of this form may be re-disclosed by the recipient and may no longer be protected by federal or state privacy rules, such as HIPAA.

I understand that treatment or payment for the care I have received at OSUWMC is not dependent on my signing this release, unless treatment is for research or the care was given to provide information to a third party.

If I am requesting records related to substance use disorder, federal law prohibits further release of my information without my written consent and requires an additional specific form to be completed before the records are provided.

_____ _____
Signature of the Patient or Person Authorized to Consent — Date Signed

_____
Relationship if not the Patient

_____ _____
Witness (optional) — Date Signed

Submit requests to one of the following:

The Ohio State University Wexner Medical Center
Medical Information Management
110 Doan Hall, 410 West 10th Avenue
Columbus, Ohio 43210-1228
Phone: (614) 293-8657

East Hospital
Medical Information Management W113
181 Taylor Avenue
Columbus, Ohio 43203 - 1779
Phone: (614) 257-2544

The James Cancer Hospital and Solove Research Institute
1st Floor James Cancer Hospital
James A061
460 West 10th Ave
Columbus, OH 43210 - 2500
Phone: (614) 293-8657

MS0001

❑ **THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER**

❑ **JAMES CANCER HOSPITAL AND SOLOVE RESEARCH INSTITUTE**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MC040184 (11/19)

Patient Name:

Medical Record Number:

Date of Birth: