



DEPARTMENT OF MEDICAL INFORMATION MANAGEMENT

University Hospitals
410 West 10th Avenue
Columbus, OH 43210-1228
Phone: (614) 293-8657

Arthur James Cancer Hospital and Richard Solove Research Institute
300 West 10th Avenue
Columbus, OH 43210-1228
Phone: (614)293-8657

University Hospitals East
1492 East Broad Street
Columbus, OH 43205
Phone: (614) 257-3191

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical Record Number: _____

For Office Use Only

Patient Name: _____ Date of Birth: ____/____/____

Social Security Number: _____ Telephone Number: _____

I Authorize (check appropriate box):

- University Hospitals OSU & Harding Behavioral Healthcare and Medicine Dodd Hall
James Cancer Hospital Clinic University Hospitals East Other (please specify):

To Release Medical Information To (check appropriate box):

- The Ohio State University Medical Center Other Name:
Med. Info. Management, 140 Doan Hall Address:
410 W. Tenth Avenue
Columbus, Ohio 43210

Purpose of Disclosure: _____

Dates of Service: _____

Medical Information To Be Disclosed:

- Inpatient Outpatient Emergency Department

Specific Reports To Be Disclosed:

- Emergency Department Reports Operative Reports Assessment
Discharge Summary Physical/Occupational Therapy Notes Treatment Plan
Laboratory Reports Pathology Reports Progress Notes
History & Physical Radiology Reports Admission Note
Other:

I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of audio, photo, or video has been designated above, if applicable. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for 60 days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. The revocation of this authorization is effective except as indicated in Ohio State University Health System's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA. I understand that Ohio State University Medical Center cannot condition my treatment or payment for health care on this Authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

X Signature of Patient or Person Authorized to Consent Date Signed

X Relationship, if not the patient

X Witness (Optional) Date Signed

For records covered by 42 CFR Part 2: This information has been disclosed to you from records protected by Federal Confidentiality Rules. 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 information to criminally investigate or prosecute any alcohol or drug abuse client.

If you have questions regarding release of information from University Hospitals (including OSU & Harding Behavioral Health, University Clinics, and Dodd Hall) or Arthur G. James Cancer Hospital and Richard J. Solove Research Institute call (614)293-8657. If you have questions regarding release of information from University Hospitals East call (614)257-3191. If you have questions regarding copy fees, contact ChartOne Customer Service at 1-800-521-COPY (2679).