

Patient Name (First, Middle, Last) [REDACTED]	Date of Birth: 08 / 17 / 1929	Last 4 digits of Patient's Social Security Number: [REDACTED]	Telephone Number: [REDACTED]
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Dates of Service to Release (From): _____ (To): _____

Specific Reports to be Disclosed:

- | | | |
|---|---|---|
| <input type="checkbox"/> Emergency Department Records | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Discharge Information | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Plan of Care | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Consults/Assessment | <input type="checkbox"/> Operative/ Procedure Reports | <input type="checkbox"/> Other: _____ |

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

Release Information From:

- | | | |
|--|---|---|
| <input type="checkbox"/> Ohio State University Wexner Medical Center | <input type="checkbox"/> Dodd Hall | <input type="checkbox"/> OSU Clinic (please specify): _____ |
| <input type="checkbox"/> Ross Heart Hospital | <input type="checkbox"/> James Cancer Hospital | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> OSU Harding Hospital | <input type="checkbox"/> University Hospital East | |

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

(Name) _____
 (Address) _____

 (Phone) _____

Release Information To: The Ohio State University Wexner Medical Center (specify provider)

Per Ohio Revised Code 3701.741, **you may be charged a fee 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.

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 365 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 The 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 The Ohio State University Wexner Medical Center cannot condition my treatment or payment for health care on this Authorization unless treatment is research-related or the care was provided solely to provide information to a third party.

For records covered by 42 CFR Part 2: **I understand that my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse patient records, and this notice accompanies a disclosure of such information.** 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.

Signature: Verbal consent patient: daughter
 [REDACTED]

Date Signed: 11/28/2019

[REDACTED]

Date Signed: 11/28/2019

Submit requests to one of the following:
 The Ohio State University Wexner Medical Center
 Medical Information Management
 N113 Doan Hall, 410 West 10th Avenue
 Columbus, Ohio 43210-1228
 Phone: (614) 293-8657

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



Patient Name: [REDACTED]

Medical Record Number: [REDACTED]

Date of Birth: 08/17/1929

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION