PROMEDICA

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Fields marked with an asterisk (*) are required to be completed.

Name (First, Middle, Last) *	**(Maiden/Alias)**	**Date of Birth***	**SSN (Last 4 Digits)**
Address	**City**	**State**	**Phone Number ***

1. **I hereby authorize the disclosure of health information about the above individual as follows.**
   The protected health information to be DISCLOSED from the following entity:

Hospital/Physician office*:			
Address	City	State	Zip Code
Phone Number	Fax Number		

2. **Person/Physician/Organization authorized to RECEIVE the information:**

Recipient *			
Address	City	State	Zip Code
Phone Number	Fax Number		

3. **Purpose of Release/Disclosure:**
   - ☐ Transfer- Physician office ☐ Payment claims/Insurance ☐ Legal Use ☐ Personal Use
   - ☐ Treatment/continued care ☐ Other (specify) _____

4. **Records to be released:***
   Please note: If no dates specified, the last 6 months of records will be released

☐ Package 1 – Pertinent Records (Discharge Summary/Physician Office Note, H&P, Procedure Reports, Consults, all Diagnostic Testing ***Specify Dates/Date Range***:
☐ Package 2 - ProMedica Physician Group Entire Record – ***Specify Dates/Date Range:***
☐ Package 3 - Hospital Entire Record – ***Specify Dates/Date Range:***
☐ Package 4 - Diagnostic Tests – ***Specify Dates/Date Range:***
☐ Package 5 – Other Records *(Please Specify):*

5. **Information should be on: and delivered via:***

Electronic PDF via	**Paper via**	**Other:**
☐ **Secure Email to :**	☐ **Fax:** fax to number listed in section 2	☐ Please describe:
☐ **UN-Secure Email to :**		
☐ **ProMedica MyChart** ☐ include Proxy(ies) Name(s): _____	☐ **Mail** –USPS Mail to address listed in section 2	
☐ **CD Mail** -USPS Mail to address listed in section 2		
☐ **CD PICK UP** –by: _____ (ID is required for picked- up)	☐ **PICK UP** – by: _____ (ID is required for picked- up)	
☐ **On-site Review** (By Appt. Only call 419-291-4172)		

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6. Required Notices

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Health Information Management department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. For Addiction Treatment and/or Behavioral Health Services Records: "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 C.F.R. 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". OAC 5122-27-06.

7. Expiration

In accordance with State law and unless otherwise revoked, this authorization must be presented before the expiration date of one year (Ohio) or 60 days (Michigan) from signature, unless an earlier expiration date is specified._____ *Note: "Does not expire", "no expiration", or "none" are not acceptable.*

X_____ **X** _____

Signature of Patient or Legally Authorized Representative **Date**

If you are the legally authorized representative of the patient, describe the scope of your authority (attach necessary proof)

☐ Parent ☐ Durable Power of Attorney for Health Care ☐ Legally Authorized Representative

☐ Personal Representative of the Estate ☐ Other (specify and attach proof) _____

For ProMedica Use Only:	
☐ Records released by Office/Department-(form will be scanned into chart) Date Processed: _____ Processed By: _____	☐ Forwarding Request to HIM for processing Date Forwarded: _____ Forwarded By:_____