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

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: