The University of Toledo Medical Center
Health Information Management
Release of Information Unit
1015 Research Drive, Toledo, OH, 43614

Authorization to Release Copies of a Medical Record

Please complete this form in its entirety so we can help you receive the information you are requesting.

Patient Name:______________________ Date of Birth:______________________

Street Address:______________________ Medical Record Number:______________________

City/State/Zip:______________________ Phone:______________________

e-mail Address:______________________ Fax:______________________

☐ Send to ☐ Send from company/Organization:______________________

Street Address:______________________

City/State/Zip:______________________ Phone:______________________

e-mail:______________________ Fax:______________________

Purpose of release/disclosure to other person/organization:

☐ Continuity of Care ☐ Request of Patient ☐ Other (specify):______________________

☐ Outpatient Surgery, Date of Service:______________________ ☐ Clinic or Office Visit, Date of Service______________________

☐ Inpatient Admission, Date of Service:______________________ ☐ Emergency Department Visit, Date of Service______________________

Information to be released: (check all that apply)

☐ Discharge Summary ☐ Emergency Department Reports ☐ Radiology/Ultrasound Reports ☐ Billing

☐ History & Physical ☐ Physician Progress Notes ☐ Laboratory Reports ☐ Complete Set of Medical Records

☐ Operative Reports ☐ Psychiatric Health Record ☐ Other:______________________

☐ Alcohol & Drug Detox/Treatment, specifically:______________________

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How much/what kind of information; explicit description of substance use disorder information that may be disclosed

Information to be: ☐ Electronic Delivery (see instructions on back) ☐ Pick Up ☐ CD ☐ Paper copy ☐ Mailed

1. I hereby authorize The University of Toledo Medical Center (UTMC), its agents and its employees to release Protected Health Information about me/my child to the recipient which may include tests results, diagnosis, treatment or other information about HIV or other communicable disease, if any, alcohol and drug information protected by Federal Regulation (42CFR Part 2), if any, and mental health information if any.
2. I am the patient, or the legally authorized representative of the patient, listed above. I request The University of Toledo Medical Center to release my protected health information (or the patients information listed above to:
3. This authorization may be revoked in writing by sending to the address at the top of this form, at any time, except to the extent that action has been taking in reliance on this authorization. Unless otherwise revoked this authorization is valid for 60 days or date/condition/event:______________________
4. I hereby waive and release the facility, its employees and attending physicians from legal responsibility or liability from the release of the above information in accordance with this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our hospital's policies and applicable law unless re-disclosure specifically prohibited by law.
6. UTMC may not condition my treatment or payment on my signing this document.
7. I have been informed that UTMC utilizes an outside contracted copy service. I have been informed that copies of my medical record(s) are subject to a copying fee, Pleases see second page regarding our fee schedule.
8. A photocopy is as valid as the original

______________________ ______________ ______________
Patient or Person Authorized to Consent — Date — Time

______________________ ______________________
Patient Signature — Relationship to Patient

Notice to Recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). 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 release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Office Use Only ID Verified: ☐ Yes ☐ No Date Received:______________________ Date Processed:______________________

Information: ☐ Mailed ☐ Picked Up ☐ Faxed Processed By: ☐ HIM Staff ☐ Other:______________________