www.heartofohiofamilyhealthcenter.org

Capital Park Family Health Center
2365 Innis Road
Columbus, OH 43224
614-416-4325

Whitehall Family Health Center
882 S. Hamilton Rd.
Columbus, OH 43213
614-235-5555

RELEASE OF INFORMATION (ROI)

PERSONAL INFORMATION

Last Name: ________________________________ First Name: ____ M.I. __________

Previous Name: _____________________________ DOB: _______________________ Social Security #: _____________________________

RELEASE OF RECORDS FROM (WHO HAS YOUR RECORDS?)

Name of clinic or organization: ____

Address: ____ City: ______________________________

State: ________________ Zip: _________________ Phone #: _____________________ Fax #: ______________________

RELEASE OF RECORDS TO (WHO NEEDS YOUR RECORDS?)

Name of clinic or organization: ____

Address: ____ City: ______________________________

State: ________________ Zip: _________________ Phone #: _____________________ Fax #: ______________________

THESE ARE THE RECORDS I WOULD LIKE TO RELEASE (CHECK ALL THAT APPLY)

☐ Discharge Summary
☐ Counselor's Discharge Summary
☐ History and Physical Exams
☐ Consultation Reports
☐ Outpatient Clinic Notes
☐ Pathology Reports
☐ Lab Reports
☐ X-Ray/Radiology Reports
☐ Films/CD's
☐ Operative Reports
☐ EKG/ECHO Reports
☐ Emergency/Urgent Care Reports
☐ Psychological Tests
☐ For MD only Pathology Slides
☐ Other ___________________________________

If you would like to release all records check here ☐ ALL

For condition or dates of treatment: ____

(If left blank we will release 1 year's worth of most recent records)

REASON FOR RELEASE

☐ Continued care by another provider
☐ Social Security disability
☐ Insurance claim
☐ Attorney review
☐ Personal Use
☐ Other ___________________________________

PATIENT ACKNOWLEDGEMENT

I understand the following:

- Except for psychotherapy notes (which are not included in my medical record) all records of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV will be released. If I do not want these to be released, I will place a check mark here________. I do not want the following records released
- If I change my mind, I may write to the address listed in the header of this document to stop the release of my records. This will not apply to records that have already been released.
- This form expires one year after I sign it or sooner (Specify here:____)
- The time period noted here may exceed one year in certain situations specified by law.
- There may be a fee for releasing these records.
- Once the records are released, the clinic or hospital releasing my records cannot prevent them from being released to a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- To be valid, this form must be filled out completely, signed and dated. A copy is valid if it has not been altered.

Patient/Guardian Signature: ____ *Date:* ________________

Staff Signature: ____ *Date:* ________________