HEART OF OHIO
FAMILY HEALTH
www.heartofohiofamilyhealth

WHITEHALL
FAMILY HEALTH
882 S. Hamilton Road
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CAPITAL PARK
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CHANTRY
FAMILY HEALTH
5560 Chantry Drive
Columbus, OH 43232
(614) 235-5555
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: ______________________________________
SOCIAL SECURITY NO.:__________________________________
DATE OF BIRTH:_______________________________________

I hereby authorize ______________________ (name of provider) to release the information requested below to the following person or entity identified below. My health care provider has authority to discuss my protected health information with the person identified, as well as to produce any records requested. The purpose of this authorization is for ____________________________.

Name (of person or entity authorized to receive information):____
Address: ____
Phone Number: (_________)__________________ Fax Number (____)__________________

INFORMATION REQUESTED:

_____ Medical records
_____ Billing Records
_____ Psychotherapy Notes
_____ Other (Please specify): ____

For the time period from ____/____/________ (mm/dd/yyyy) to ____/____/________ (mm/dd/yyyy) :

I understand that I may be charged reasonable cost-based fees as allowed by law, for all postage and copying costs and other agreed-upon special services.

I understand that information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the federal privacy requirements, including HIPAA, 45 C.F.R., part 164.

This authorization permits the release of information which may be related to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse.

I understand that I have the right to revoke this authorization at any time by sending a written revocation to the above-specified entity, but that this authorization cannot be revoked to the extent that protected health information has been previously provided in reliance on this document.

I understand that a refusal to sign this authorization will not result in a denial of health care by any health care provider.

A copy of this authorization may be used as an original. This authorization may remain valid for a maximum period of one year following the signature date.

_______________ ____

Date Signature of Patient or Legal Representative

____

Printed Name

____

Legal Relationship to Patient (Please attach documentation in support of authority)