www.heartofohiofamilyhealth.org

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

Whitehall Family Health Center
882 South Hamilton Road
Columbus, Ohio 43213
614-235-5555

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: ____
SOCIAL SECURITY NO.: ____
DATE OF BIRTH: ____

☐ I hereby authorize Heart of Ohio Family Health Care Centers 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 __________________________.

☐ I hereby authorize ____________________ (name of provider), (___) ____________(fax # of provider) to release the information requested below to the following:

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

INFORMATION REQUESTED:

_____ Medical records
_____ Billing Records
_____ Behavioral or mental health services and/or treatment for alcohol and/or drug abuse.
_____ 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).

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.

Heart of Ohio Family Health Care Centers may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign this authorization.

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)

Revision August 30, 2016