THIS FORM MUST BE COMPLETED IN THE ENTIRETY
BY THE PATIENT OR THE PATIENT'S AUTHORIZED REPRESENTATIVE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name		Maiden Name
Social Security Number	Date of Birth	Phone Number
Address		

1. Provider Making the Use or Disclosure: I authorize Trihealth Surgical Institute (referred to as "Health Care Provider") to use and/or disclose my/the patient's individually identifiable health information as described below.

2. Recipient of the Information: I authorize the following person(s) or organization(s) to receive the information:

NAME

STREET ADDRESS

CITY, STATE AND ZIP CODE

3. Type of Information to be Released: Check the type of information that you want to be used or disclosed pursuant to this Authorization—

A. Medical Records: ***CHECK ONE***

☐ **All medical records; *or***

☐ **I only want the parts of my medical record described below to be disclosed**:

B. Billing Records:

☐ **All billing records including itemized statements**

C. Dates of Treatment: ***CHECK ONE***

☐ **All dates of treatment; *or***

☐ **I only want records for the following dates of treatment to be disclosed**:

Further, I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism and/or Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric/psychological conditions and/or psychiatric/mental health treatment.

4. Purpose for the Use or Disclosure: The purpose for the use or disclosure is at the patient's request (if the

request is initiated by the patient) or one or more of the following reasons: ***CHECK ALL THAT APPLY***

☐ **Lawsuit/legal preparation** ☐ **Applying for disability**
☐ **Applying for insurance** ☐ **Other:**_____

5. Oral Communications: I understand that this Authorization allows the Health Care Provider (and its employees) to discuss my protected health information described herein with the recipient of the information.

6. Your Refusal to Sign this Authorization: The Health Care Provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization the Health Care Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

7. Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the 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. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

8. Revocation: I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

9. Expiration: This Authorization will expire one year after the date below, or sooner by choice, in which case this Authorization will expire on _____.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**

Printed name of patient's representative, if applicable:_____
Relationship to patient:
☐ Parent ☐ *****Legal Guardian ☐ *****Other:_____

*****Legal documentation of Representative's authority must accompany this Authorization.