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

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name		**Maiden or Other Name(s)**
Date of Birth	**Phone Number**	**Email Address**
Address		

1. **Provider Making the Use or Disclosure:** I authorize the below Provider(s) (referred to as "Health Care Provider") to release my/the patient's individually identifiable health information as described below in Section 3. ***Specify Location and Provider below.***

Physician/Provider Locations *(Use for all primary care and specialist visits except those specifically listed under Hospital Locations*)*:
❑ TriHealth Physician Partners *(Add specific Location & Provider below)*
Includes:
- Group Health
- Queen City Physicians
- TriHealth Priority Care
- TriHealth Walgreens
- All Others

Hospital Locations *(Do not use for physician/provider offices within a hospital building unless specified below*)*:
❑ Bethesda Arrow Springs
❑ Bethesda Butler
❑ Bethesda North
❑ Bethesda Family Practice*
❑ Good Samaritan – Clifton
❑ Good Samaritan Faculty Medical Center*
❑ Good Samaritan Western Ridge
❑ Good Samaritan – All Other Locations
❑ McCullough-Hyde Memorial
❑ TriHealth Clinton Regional
❑ TriHealth Surgery Center Anderson

Location(s): _____

Provider(s): _____

2. **Recipient of the Information:** I authorize the Health Care Provider to release the information described in this release to: ❑ **Check here if recipient is same as patient information above.**

Only complete below name/contact if recipient and/or contact information is different than patient details above.

Name: _____ Phone: _____ Fax: _____

Street Address: _____

City/State/Zip: _____ Secure Email Address:_____

Preferred Method of Delivery: ❑ MyChart ❑ Print ❑ Fax ❑ Secure Email ❑ Electronic Media (CD or flash drive)

3. **Type of Information to be Released:** Describe the type of information that you want to be disclosed pursuant to this Authorization.

❑ Billing Records ❑ Hospital Medical Records ❑ Images (CD) ❑ Physician Office Notes

Date(s) of Treatment (Please DO NOT leave blank):

_____

_____

PHI to be Released: ❑ Test Results (Lab & Imaging) ❑ Abstract of Health ❑ Entire Encounter ❑ Other:_____

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) an/or psychiatric/psychological conditions and/or psychiatric/mental health treatment.

4. **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.
5. **Purpose for the Use or Disclosure:** The purpose for the 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 ❑ Medical Care

   ❑ Patient Request/Personal Use ❑ Other (Must specify):_____

6. **Oral Communications**: I understand that this Authorization allows the Health Care Provider (and its team members) to discuss my individually identifiable health information described herein with the recipient of the information.
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 enough 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 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 on the date or event specified below. Note: You may not indicate that there is no expiration; for example, the words "does not expire" or "no expiration" or "none" are not acceptable**. If no date or event is specified below, this authorization will expire in one year.** However, if the records to be used or disclosed pursuant to this Authorization concern psychiatric, psychological and/or mental health treatment and no date or event is specified below, this Authorization will expire in 90 days.

   Expiration Date or Event:_____

_____ _____

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.

Please note that there may be a charge to copy records.
The Health Care Provider may use a copy service, and it may bill you directly.