

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



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

For Bethesda Healthcare, Inc./TriHealth Corporate Health Use Only

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

1. Provider Making the Use or Disclosure: I authorize Bethesda Healthcare, Inc. (referred to as "TriHealth Corporate Health") to release my/the individual's protected health information as described below in Section 3.

Specific Location/Area of TriHealth Corporate Health from whom I/the individual received services:

- TriHealth Occupational Medicine Center (*occupational medicine and health services at a TriHealth center*)
- On-Site wellness, medical or occupational health services (*at place of employment*)
- Executive Health program (*in-depth medical and wellness examination*)
- TriHealth EAP® - counseling (*employee assistance offered through employer or family member's employer*)
- Mobile Health and Wellness Unit (*occupational medicine services (such as pre-placement exams)*)
- Other (must specify) _____
- Unsure/Don't know

2. Recipient of the Information: I authorize TriHealth Corporate Health to release the information described in this release to: **Check here if recipient is the same as individual information above.**

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

Name: _____ Phone: _____ Fax: _____

Street Address: _____

City/State/Zip: _____ Email Address: _____

Preferred Method of Delivery: **Print** **Fax** **Secure Email** **Electronic Media**

3. Records to be Released: Describe the type of records that you want to be disclosed pursuant to this Authorization.

- All Records**
- Immunization/Injections Record**
- Drug & Alcohol Test Results**
- Fitness for Duty or mandatory referral evaluation results/recommendations** (*This does NOT include the complete independent medical examination (IME) report created by the psychiatrist that I/the individual met with for fitness for duty or mandatory referral - check the next box below if requesting complete IME*).
- Independent medical examination report (IME)** (Created by psychiatrist as part of fitness for duty or mandatory referral)
- Biometric Screening/Test Results**
- OSHA Clearance Results**
- Other (please specify):** _____

Date(s) of Treatment (Please specify "all dates" or specific dates/date range of services - DO NOT leave blank):

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. **Your Refusal to Sign this Authorization:** TriHealth Corporate Health may not condition treatment on whether or not you sign this Authorization.

If the purpose of performing the medical examination or service is solely to create information for disclosure to a third party (such as your employer or prospective employer), TriHealth Corporate Health has the right to and will condition the performance of a medical examination or service on whether or not you sign this Authorization.

5. **Purpose for the Use or Disclosure: Check All That Apply**

Individual Request/Personal Use Employment/Pre-employment Screening Medical Care

Applying for disability Applying for insurance Lawsuit/Legal Preparation

Other (Must specify): _____

6. **Oral Communications:** I understand that this Authorization allows TriHealth Corporate Health (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. The information disclosed pursuant to this Authorization shall not include Substance Use Disorder Records, which are protected by Federal confidentiality rules (42 CFR part 2). 42 CFR Part 2 prohibits unauthorized use or disclosure of these records. 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 TriHealth Corporate Health in writing by emailing _2cc243@TriHealth.com or sending a letter to the attention of the Medical Records Department, TriHealth Corporate Health, 4665 Cornell Road, Ste 350, Cincinnati, OH 45241. I understand that if I revoke this Authorization, it will not affect any actions that TriHealth Corporate Health took before it received and processed my revocation request.

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.**

Expiration Date or Event: _____

SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S REPRESENTATIVE

DATE

Printed Name of Individual's Representative, if Applicable:

Relationship to Individual: 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.

TriHealth Corporate Health may use a copy service, and it may bill you directly.