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 First Name	**Patient Last Name**	**Maiden Or Other Name(s)**
Date Of Birth	**Phone Number**	
Address		

1. **Provider Making the Use or Disclosure**: I authorize ________________________________ (referred to as "Health Care Provider") to release any and all of my/the patient's individually identifiable health information, including but not limited to, billing and treatment records to the individual or entity set forth below:
   Name: ______________________ Phone: ____________________ Fax: ________________________
   Street Address: ____
   City/ST/Zip: ____
   Email Address (If requesting PHI be emailed): ____

   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, if any.

2. **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 this information to the person or organization specified above.

3. **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
   _______ Other: ____

4. **Oral Communications**: I understand that this Authorization allows the Health Care Provider (and its employees and agents) to discuss my individually identifiable health information described herein with the individual or representative from the entity specified above in Section 1. If the individual specified above is an administrative agency, court, attorney or the entity above is a law firm, this includes discussing my

individually identifiable health information at a deposition, hearing, trial or other legal proceeding.

6. **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 medial 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 if 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.

7. **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.

8. **Expiration**: This Authorization will expire one year after the date below, or sooner by choice, in which case this Authorization will expire on: ________________ (if applicable, insert date of the foregoing line). 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).

____ _______________________________________

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 Healthcare Provider may use a copy service and it may bill you directly.