- Administrative Use Only – Driver's license number:

Authorization: Release of Information Form

Patient Name: _____ Date of Birth: _____

Telephone Number: _____ Social Security #: _____

Address: _____

I authorize the use or disclosure of the above named individual's health information as described below:

☐ Adena Health System – including all locations
☐ Adena Greenfield Medical Center
☐ Adena Retail Pharmacy
☐ Adena Regional Medical Center ☐ Adena Pike Medical Center
☐ Adena Medical Group Provider: _____
_____

To: _____ Release records to _____ Obtain records from _____ Exchange verbal information with

Name: _____

Address: _____

Dates of Service to Release – From: _____ To: _____

(Reports must have been generated prior to the signing of this authorization.)

_____ History & Physical
_____ Discharge Summary
_____ Operative / Procedure Report
_____ Consultations
_____ Drug / Alcohol Treatment (Abuse)
_____ All Test Results
_____ X-ray / Imaging CD
_____ X-ray / Imaging Report
_____ Emergency Room Report
_____ Psychotherapy (requires approval by psychotherapist)
_____ Clinic Notes
_____ Entire Record
_____ Other
_____
_____ Behavioral and Mental Health Services (other than psychotherapy notes)
_____ HIV Testing, HIV Test Results, Diagnosis of HIV, AIDS, ARC or other AIDS related disease

Purpose of Disclosure: _____ Continuation of Medical Care _____ Insurance _____ Disability _____ Personal
_____ Legal Reasons (including trial preparation and court testimony)

I understand the following:

- That authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment.
- That once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.
- That unless specified differently, this authorization will expire (date or event) _____ or if I fail to specify, this authorization will expire ***one year*** from the date of the signature.
- That I have the right to revoke this authorization at any time and that I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has been released in good faith prior to receipt of written revocation. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- That record copies will be released in paper format unless requested as electronic by initialing here _____. Please provide email for such: _____.
- ***That with the exception of records being copied for continuity of care, for insurance company or other third party reimbursement, there WILL be a charge for copies of records in accordance with Ohio Law.***

_____ / _____ _____ / _____
Signature of patient or patient's representative Time / Date Signature of witness Time / Date

_____ _____
Printed name of patient or representative Printed name of witness

If signed by patient's representative, relationship to patient: _____
If patient representative, provide documentation or explanation of your authority to act for the patient. (Attach copy). Revised 2/9/2018