UC Health Weight Loss Center
7690 Discovery Drive, Suite 2300
West Chester, Ohio 45069

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

This authorization is according to federal Privacy Laws.

Patient Information:

Last Name: _____ **First:** _____ **Middle:** _____

Maiden Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

SS Number: ___ - ___ - ____ **Date of Birth:** ___ / ___ / ____

Phone: ( ) -

I, the above identified person, do herby authorize the release of my PHI as indicated – Identify individual/group/entity and list addresses:

From: _____

To: **University of Cincinnati**
Weight Loss Center
7690 Discovery Drive, Suite 2300
West Chester, Ohio 45069
Phone: (513) 939-2263 Fax: (513) 874-4579

I understand that this authorization is voluntary and that it may include information relating to *AIDS, HIV infection behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse*. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be redisclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

This authorization covers the following periods of healthcare:

☐ **All periods of Healthcare**

☐ **From:** / / **To:** / /

☐ **From:** / / **To:** / /

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

☐ **All results of test(s) and all physician dictation**
☐ **History and Physical**
☐ **Office Visits**
☐ **All results of test(s) and all physician dictation**
☐ **Consultation Reports**
☐ **Other (please specify** _____

☐ **Radiology Reports**
☐ **Radiology Images**
☐ **Laboratory/Operative Reports**
☐ **Psychotherapy Notes**
☐ **Billing Records (itemized statements, EOB's, HCFA1500)**

This information is being disclosed for the following purposes:

- ☐ **Legal Reasons**
- ☐ **Continued Care and Treatment**
- ☐ **At the Request of the Patient**
- ☐ **Insurance**
- ☐ **Workman's Compensation**
- ☐ **Personal Use**
- ☐ **Disability**
- ☐ **Media Interview/Release: Any direct or indirect Payment to a UC Physicians Practice Group from a 3rd party?**

Yes _____ **No** _____

Other (Explanation) _____

I understand that I/my legal representative have the right to revoke this authorization in writing, at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

This authorization will expire in 60 days unless otherwise specified (insert date or specific event)

_____

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature: _____ **Date:** _____

If you are signing as a legal representative for an individual, read and sign below:

I, _____, hereby certify and attest that I am the duly authorized legal representative of

_____ and that I have the lawful authority regarding the use and or disclosure of Protected Health Information of such individual for the purposes set forth in this document.

Signature:

Print Name: **Date:**

YOU SHOULD RECEIVE A COPY OF THIS AUTHORIZATION FORM AFTER SIGNING.

Received By: _____ **Date Received:** _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.