Authorization to Use or Disclose Protected Health Information

Last Name _____ First Name _____ Middle_____ Date of Birth _____

Maiden Name_____ Last 4 of Social Security number _____

Address (Street, City, State, ZIP Code _____

Telephone Number_____

Request info be released from: ☐ UCMC ☐ WCH ☐ Drake ☐ UCP Office ☐ Other

Request info to be released to _____
Name of facility or person and complete address

Address_____

City/State/Zip_____

Treatment Dates_____

Purpose of Request ☐ Self ☐ Continuity of Care ☐ Disability ☐ Legal ☐ Insurance ☐ Other _____

The following information to be disclosed (please check):	☐ Discharge Summary ☐ History and physical examination ☐ Consultations (including psychiatric evaluations) ☐ Operative report or procedure reports ☐ Emergency Department record ☐ Laboratory reports (including drug screens)	☐ Radiology or x-ray reports ☐ Interdisciplinary records (progress notes) ☐ Medication Records ☐ Nursing notes ☐ Physician orders ☐ Other _____
Sensitive Information	I understand that the information in my records may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.	
Right to Revoke	I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that revocation will not apply to information that has already been released based on this authorization.	
Expiration	Unless otherwise revoked, this authorization will expire on the following date or when the following event or condition occurs: _____ If I do not specify an expiration date, event, or condition, this authorization will expire in 60 days.	
Redisclosure	I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.	
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in *CFR* § 164.524. If I have any questions about disclosure of my health information, I can contact **UCMC at 513-584-6146; WCH at 513-298-7750; Drake at 513-418-2666; or University of Cincinnati Physicians Company at 513-245-3710.**	

Print Name: _____ Date: _____ Time: _____

Signature of Patient or Legal Representative *: _____

If Signed by Legal Representative, relationship to patient _____
Legal representative must provide a copy of guardianship, Executor of Estate, or POA documents

---

Office Use Only: Received by: _____ Medical Record number: _____ Date Received: _____