ROICOR

UC Health

AUTHORIZATION FOR USE and/or DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Maiden Name _____
Address _____ City _____ State _____ Zip _____
Last 4 of Social Security Number _____ Date of Birth _____ Telephone Number _____
Specific Facility Needed ☐ University of Cincinnati Medical Center, LLC (UCMC) ☐ Daniel Drake Center for Post-Acute Care, LLC (Drake) ☐ West Chester Hospital, LLC ☐ OTHER _____
The purpose of this request is for ☐ Continuity of care ☐ Legal ☐ Insurance ☐ At the request of Individual ☐ Disability ☐ Other _____

I authorize UC Health to use and/or disclose the above named individual's health information as described below:
Date(s) of Treatment _____
The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

☐ Face Sheet	☐ Discharge Summary	☐ History & Physical	☐ Treatment Plans
☐ Consultation Report	☐ Progress Notes	☐ Operative Report	☐ Therapy Notes
☐ Pathology Report	☐ Lab Report	☐ X-Ray Report	☐ Abstract* (see back page)
☐ EKG/ECG Test	☐ Physician Orders	☐ Nursing Notes	☐ Entire record
☐ ED Report	☐ Outpatient Report	☐ Medication Record	☐ Psychotherapy records

☐ Other _____

I understand that the information in my health record may include information relating to **treatment, diagnosis, or testing of drug or alcohol abuse**, **drug-related conditions**, **alcoholism**, **psychiatric/psychological conditions**, **Acquired Immune Deficiency Syndrome (AIDS)**, and/or tests for antibodies to **Human immunodeficiency virus (HIV).**

The information identified above may be used by and/or disclosed to the following individual or organization:

Name _____
Address _____
_____
Phone _____ **FAX** _____

I understand that I have a right to revoke this authorization at any time. I understand that if I want to revoke this authorization that I must do so in writing and present my written revocation to: Health Information Management, Release of Information, University of Cincinnati Medical Center, 234 Goodman St. Cincinnati, OH 45219. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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. 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 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.
I understand that this authorization shall remain in effect for 60 days from the date of my signature below unless I specify an earlier or later expiration date in this space _____.
I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand that I will be charged a copy fee for copies not mailed directly to a health care provider. ORC 3701.742
I understand authorizing the use or disclosure of the information identified above is voluntary.

_____ _____
Signature of patient or **legal representative Date**

If signed by legal representative, relationship to patient _____
***Legal representative must provide guardianship, executor of estate, power of attorney papers with this form*

Drake: 513-418-2666
Fax: 513-418-2533

UCMC: 513-584-6146
Fax: 513-584-0739

West Chester: 513-298-7750
Fax: 513-298-7765

OVER FOR SIDE 2 ➔

ROICOR

UC Health

Quick Tips for Requesting Your Medical Record

- For "Continuity of care" the receiving caregiver typically only wants to receive an "Abstract" of key information from the medical record. This same "Abstract" sent to caregivers also almost always meets the needs for individual use.

- A Medical Record "Abstract" contains the following:
  - ✓ Discharge Summary – this document is a summary of the care, treatment, services provided and progress toward established goals of an inpatient stay
  - ✓ Emergency Record – this record documents the care, treatment and services provided for a visit to the emergency room, as well as the After Visit Summary (AVS)
  - ✓ History & Physical – this form details the present illness or care needs and notes any relevant past history
  - ✓ Operative Report(s) – this report details the surgeon's findings, technical procedures used, specimens removed and postoperative diagnosis
  - ✓ Consultation(s) Report(s) – this report documents the findings of a physician requested to examine a patient
  - ✓ X-Ray Reports, Labs, or other Testing
  - **There is a charge for medical record copies.** Requestors will be sent a prepayment invoice from our copying service MRO and upon determination of total cost and once payment is received, the charts will then be sent.

    Please note: The state of Kentucky is the only place that offers 1 FREE copy of your chart, NOT Ohio**

  - The Health Insurance Portability and Accountability Act (HIPAA) allows healthcare providers 30 days to process records. UCMC puts forth every effort to provide records more timely, however occasionally the full 30 days are required to fulfill your request.

  - If the Authorization form is signed by a legal representative of the patient, they MUST provide a copy of their guardianship, executor of estate, and/or power of attorney papers with the request form.

Revised date: 12/11/14db