OSUPhysicians, Inc.

Medical Record Number:_____
(For Office Use Only)

Authorization to Release Medical Information

Patient Name (First, Middle, Last)	**Date of Birth:**	**Last 4 digits of Patient's Social Security Number:**	**Telephone Number: ( )**

Dates of Service to Release (From): _____ (To): _____

Specific Reports to be Disclosed:

❑ Emergency Department Records	❑ Progress Notes	❑ Laboratory Reports
❑ Discharge Information	❑ Therapy Notes	❑ Pathology Reports
❑ History and Physical Exam	❑ Plan of Care	❑ Radiology Reports
❑ Consults	❑ Operative/ Procedure Reports	❑ Other:_____

Purpose of Disclosure: ❑ Medical Treatment ❑ Disability ❑ Insurance ❑ Legal Reasons ❑ Personal ❑ Other:

Release Information From:

❑ Ohio State University Wexner Medical Center	❑ Dodd Hall	❑ OSUP Clinic (please specify):_____
❑ Ross Heart Hospital	❑ James Cancer Hospital	
❑ OSU Harding Hospital	❑ University Hospital East	❑ Other (please specify):_____

Release Information To: ❑ Other (specify recipient and complete address below)	**Release Information To:** ❑ Ohio State University Physicians, Inc. (specify provider)
(Name)	(Name)
(Address)	(Address)
(Phone)	(Phone)

Per Ohio Revised Code 3701.741, **you may be charged a fee for copies of medical records.** If you have questions about an invoice you have received, please contact CIOX Health at 1-800-367-1500. CIOX Health is a business associate of Ohio State University Physicians, Inc. I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/ or AIDS (Acquired Immunodeficiency Syndrome), and /or may include results of an HIV test or the fact that an HIV test was performed. Information in the form of audio, photo or video has been designated above, if applicable. A separate authorization is required for the release of psychotherapy notes. I expressly consent to the release of information designated above. This authorization is valid for **365** days, unless revoked by my written notice, provided said notice is received prior to release of the above designated information. ***The revocation of this authorization is effective except as indicated in The Ohio State University Health System's Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA.*** I understand that Ohio State University Physicians cannot condition my treatment or payment for health care on this Authorization unless treatment is research- related or the care was provided solely to provide information for a third party.

For records covered by 42 CFR Part 2: **I understand that my records are protected under the Federal Regulations governing confidentiality of Alcohol and Drug Abuse patient records, and this notice accompanies a disclosure of such information.** This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Signature of the Patient or Person Authorized to Consent — Date Signed

Relationship if not the Patient

Witness (optional) — Date Signed

Submit requests to the following:

Ohio State University Physicians, Inc.
ATTN: CIOX
700 Ackerman Road, Ste. 6106
Columbus, Ohio 43202

***Please write in your home address and email address:**

Home Address_____

_____

_____

Email Address_____