Authorization for Release of Protected Health Information

Patient Name: ______________________________ Date of Birth: ______ /______ /______

Social Security Number: ______________________________ Provider: ______________________________

Address: ______________________________ Telephone: ______________________________

Information Requested

Entire Medical Record: ☐ Yes ☐ No If no, please specify documents or dates of service: ______________________________

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I would like copies of my health information indicated in the section above sent:

From: ______________________________ To: ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I authorize the release of health information contained in my medical records including:

- Information regarding communicable diseases and infections, as defined by statue and Ohio Department of Public Health rules, which include venereal disease, Tuberculosis, Hepatitis A,B,C, Human Immunodeficiency Virus (HIV) and HIV testing.
- Acquired Immunodeficiency Syndrome (AIDS), and AIDS related complex (ARC) and ____________________ (specify).
- Alcohol and drug abuse treatment information protected under the regulations in CFR 42, part 2.
- Mental health treatments records, psychological services and social services information including communications made by me to a social worker, therapist or psychologist.
- Genetic testing and information.

Purpose of Disclosure: (check one) ☐ Attorney/Legal ☐ Continued Patient Care ☐ Insurance

☐ Personal Use ☐ Disability ☐ Other: ______________________________

It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or part to any other agency, organization or person. I further understand that correspondence, patient discharge instructions and records from healthcare providers other than Avina Women's Care will not be released unless specifically requested above.

This consent may be revoked at any time by writing to the address above, except for any action that has already been taken in reliance upon it. This authorization will expire 30 days from the date signed.

I understand that the health information that is released under this authorization may be subject to re-disclosure by the recipient, and the privacy of my health information may no longer be protected by the law. I also understand that the doctor, health care provider or health plan from whom my medical information is requested in this authorization, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

A faxed copy of this authorization will have the same effect as the original.

A fee for copying records is due upon request or receipt if records are copied for the patient. If records are copied for another physician's office/hospital, there is no charge.

Signature of Patient or Legal Representative: ______________________________ **Date:** ______________

Relationship to Patient: ______________________________