**Ohio State University Physicians, Inc.**
**Medical Records Release ("Authorization") Form**

OSUPhysicians,Inc.

Patient Name:_____ Last 4 Digits of Social Security #.:_____

Date of Birth: _____ Telephone #: _____

**I hereby authorize** the release of my (my child's) Medical Information to:

| Physician or Site Authorized to RELEASE My Information: | Physician/Site/Person Authorized to RECEIVE My information: |
|---|---|
| ☐ OSU Physicians, Inc. | ☒ OSU Physicians, Inc. |
| ☐ OTHER (complete the below) | ☐ OTHER (complete the below) |
| Name: _____ | Name: _____ |
| Address: _____ | Address: 3691 Ridge Mill Hilliard, OH 43026 |
| Phone: _____ | Phone: 614 6889220 |
| Fax: _____ | Fax: 614 6889177 |

Purpose of disclosure: ☐ Medical Treatment ☐ Disability ☐ Insurance ☐ Legal Reasons ☐ Personal ☐ Other:_____

Dates of Service: From_____ To_____

**Type(s) of Medical Information to be disclosed ("X" all appropriate boxes):**

| | | |
|---|---|---|
| ☐ History and Physical | ☐ Lab Report(s) | ☐ Complete medical record |
| ☐ Operative Report | ☐ EKG(s) | |
| ☐ Assessment | ☐ EEG | ☐ Other (Specify) _____ |
| ☐ Treatment Plan | ☐ Endoscopy Report(s) | |
| ☐ Progress Notes | ☐ Radiology Reports(s) | |
| ☐ Discharge Summary | ☐ Pathology Report | |

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I understand and acknowledge that this Authorization extends to all or part of the records designated above. 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. ***A separate authorization is required for the release of psychotherapy notes or for the release of medical information for research purposes.*** I understand that I may revoke this Authorization at any time after I have signed it by providing OSUP with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my medical information can no longer be disclosed pursuant to this Authorization except to the extent that disclosures have already been made in reliance upon this Authorization.

This Authorization is valid for one year, unless an earlier date or condition/event is specified here _____ or unless revoked by me in writing before the release of the above designated information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA. I understand OSU Physicians cannot condition my treatment or payment for health care on this authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

X_____ _____

Signature of Patient (or Patient Representative) Date Signed

***If this Authorization is signed by a legal representative of the patient (for example, the parent or legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (check applicable box and/or explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.**

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Health Care Proxy or Surrogate
- ☐ Administrator/Executor of Estate

**For records covered by 42 CFR Part 2: 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 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.

# CHECKLIST

## AUTHORIZATION REQUIREMENTS UNDER THE HIPAA PRIVACY REGULATIONS

***Applicability:*** *This "checklist" is applicable whenever the Protected Health Information of a patient will be used or disclosed for purposes other than Treatment, Payment, or Health Care Operations or those for which no Authorization is required and OSUP receives an authorization form from an outside source.* ***(Whenever possible, OSUP's standard form shall be used. See OSUP's HIPAA Privacy Regulations Compliance Manual Policy and Procedure No. [7] for further information on the use of Authorizations.)*** *State law may require certain additional language for the release of Protected Health Information that includes substance abuse treatment information, AIDS/HIV status information, and/or mental health records.* ***Do not*** *use this checklist for Authorizations for research-related uses and disclosures of Protected Health Information.*

Does the authorization contain:

- ☐ a statement of OSUP's ability or inability to condition treatment, payment, or enrollment or eligibility for benefits on the Authorization, including the consequences to the patient of a refusal to sign the Authorization if OSUP may condition treatment, payment, or enrollment or eligibility for benefits on failure to obtain such Authorization.

- ☐ a description of the Protected Health Information to be used and/or disclosed that identifies the information in a specific and meaningful way.

- ☐ a description of ***each*** purpose of the requested use and/or disclosure of Protected Health Information. (The statement "at the request of the individual" is a sufficient description of the purpose when the patient initiates the Authorization and does not or elects not to provide a statement of the purpose.)

- ☐ the name or other specific identification of the person(s) or class of persons authorized to make the requested use and/or disclosure.

- ☐ the name or other specific identification of the person(s) or class of persons to whom you may make the requested use and/or disclosure.

- ☐ a statement of the patient/subject's right to revoke the Authorization in writing, the exceptions to the right to revoke, and a description of how the patient/subject may revoke the Authorization, or, to the extent that the exceptions to the right to revoke and a description of how the patient/subject may revoke the Authorization is contained in the Notice of Privacy Practices, a reference to this Notice of Privacy Practices.

- ☐ an expiration date or an expiration event that relates to the individual or the purpose of the use and/or disclosure.

- ☐ a statement that Protected Health Information used and/or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected under HIPAA's Privacy/Confidentiality requirements.

- ☐ the date and signature of the individual, and, if the Authorization is signed by a personal representative of the individual, a description of such personal representative's authority to act for the individual.

A copy of the Authorization should be provided to the individual.