ADAMS COUNTY
REGIONAL MEDICAL CENTER
230 Medical Center Drive
Seaman, OH 45679

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

Patient Name:_____ _____ _____
Date of Birth **Social Security Number**

1. I hereby authorize Adams County Regional Medical Center to release my information to:

_____ **Telephone #:**_____

Address:_____

2. I authorize the following information to be released: **Treatment Dates:**_____

( ) Summary Sheet	( ) Progress Notes	( ) Discharge Summary	( ) All Behavioral Health Records
( ) History & Physical	( ) Operative Report(s)	( ) Consultation Reports	
( ) Laboratory Report(s)	( ) Radiology Report(s)/ Film	( ) Pathology Report(s)	( ) Pediatric Records
( ) Endoscopy Report (s)	( ) Physical Therapy	( ) ER Record	
( ) EKG(s)	( ) CT/MRI Report(s)/ Film	( ) Complete Medical Record	
( ) Clinic Record(s)	( ) Nurse Note(s)	( ) Physician Orders	

( ) Other;_____

3. This authorization includes release of records relating to:
_____ HIV test results _____ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment

4. The above information is released at the request of the individual unless otherwise marked for the following purpose and that purpose only:
_____Continuation of Care _____Legal Purposes _____Insurance Purposes _____Employer Requirement
_____Personal Reasons _____Other:_____

5. Revocation Process: I understand that I may, by placing my request in writing to the Privacy Officer, revoke this Authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. This Authorization will expire 60 days from the date of my signature or as otherwise specified by date, event or condition as follows:_____.

6. Right to Copy/Voluntary Disclosure: I know I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

7. Health Plan/ Insurance Issuers – Conditions: I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan or eligibility for its benefits. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.

8. Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization; may deny the release of protected health information, if it has reason to believe (1) this authorization has been altered or (2) this is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

9. **REDISCLOSURE:** I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal confidentiality rules.

PROHIBITION OF REDISCLOSURE: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.

Information has been released per authorization by (Employee) _____ on date:_____

_____ _____
Patient's Signature (Photo identification required) Date (Must be within 60 days)

_____ _____
Signature of Other Individual Relationship of Other to Patient

Attach Document to Prove Authority to Act on Behalf of Patient