OhioHealth Primary Care Physicians
Authorization for Use or Disclosure of Protected Health Information (PHI)

AUTHORIZATION FOR PATIENT RECORDS

I hereby authorize my protected health information to be (check ✓ one from each row):

______ **Disclosed TO:**	______ **Obtained FROM:**	**OhioHealth Primary Care Physicians - Drs. Frantz, Grund and Stella Elder** 248 Blymyer Avenue Mansfield, Ohio 44903 Telephone: (419) 524-2212 Fax: (419) 524-9040
______ **Disclosed TO:**	______ **Obtained FROM:**	**Name/Organization:**______ Address: ______ City/State/Zip Code: ______ Telephone: ______ Fax: ______

INFORMATION REQUESTED

I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to the privacy officer at MedCentral Primary Care-Blymyer. Unless revoked, this authorization will expire one year from the date of signature or on the following date: ______. I understand that a revocation is not effective to the extent that MedCentral Primary Care-Blymyer has relied on the use or disclosure of the PHI. I understand that information disclosed may be subject to re-disclosure by the recipient and no longer be protected by federal or state law. MedCentral Primary Care-Blymyer is hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein. I understand that I have the right to inspect or copy the PHI to be used or disclosed as permitted under federal law, and I have the right to refuse to sign this authorization and/or receive a signed copy of this authorization.

❑ **ALL** medical records without exception, including clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse texting and treatment, sexually transmitted disease, consultation, secondary records, etc.

❑ **PARTIAL** medication records, which may include HIV testing, mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease, and other sensitive information. Please specify areas to be released:

❑ Lab reports	❑ EKGs	❑ Consultations	❑ Progress Notes
❑ Pathology reports	❑ PFTs	❑ Discharge Summaries	❑ Emergency Room Reports
❑ X-ray reports and films	❑ Procedures	❑ Operative Reports	❑ History/Physical Exams
❑ Cardiac Catheterizations	❑ Other (list)______		

Treatment/admission dates to be included: ______

This PHI is being used or disclosed for the following purposes:

❑ Continuity of Care (Primary MD, Specialist, Hospital Care)
❑ Insurance company or other Third Party Reimbursement
❑ Pending legal action (Worker's Compensation, Disability, Liability, or Malpractice)
❑Other: ______

PATIENT INFORMATION

Patient or Representative Signature: ______ Date: ______

Patient Printed Full Name: ______

Patient Representative Printed Name: ______ Relationship: ______

Date of Birth: ______ Social Security Number: ______ - ______ - ______

Address: ______

City: ______ State: ______ Zip Code: ______

Home Phone: (______)______ Additional Phone: (______)______

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