ROICOR

UC Health

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (RELEASE OF INFORMATION)

UCH-ROI-01, Rev. 10/17

Last Name _____ First Name _____ Middle_____ Date of Birth _____

Maiden Name_____ Last 4 of Social Security Number _____ Telephone Number_____

Address (Street, City, State, ZIP Code) _____

Please select location(s) you are requesting information to be released from:

	☐	☐	☐	☐
Location	Daniel Drake Center for Post-Acute Care (DDC)	University of Cincinnati Medical Center (UCMC)	University of Cincinnati Physician Company (UCPC)	West Chester Hospital (WCH)
Mailing Address	UC Health: Medical Records Services University of Cincinnati Medical Center, 234 Goodman St.; ML0738 Cincinnati, OH 45219		MRO – Suite UCP Release 2830 Victory Parkway Cincinnati, Ohio 45206	UC Health: Medical Records Services West Chester Hospital 7777 University Drive, Suite A West Chester, OH 45069
Phone Number	(513) 584-0444		(513) 245-3711	(513) 298-7750
Fax Number	(513) 584-0739		(513) 245-3706	(513) 298-7765

Treatment Dates_____

Please Release Medical Information to the following Recipient:

Name of Person or Organization: _____

Address _____ City: _____ State: _____ Zip: _____

Recipient Phone #: _____ Recipient Fax #: _____

Purpose of Request ☐ **Self** ☐ **Continuity of Care/For another provider** ☐ **Disability** ☐ **Legal** ☐ **Insurance**

The following information to be disclosed (please check):	☐ Abstract ☐ Discharge Summary ☐ History and physical examination ☐ Consultations (including psychiatric evaluations) ☐ Operative report or procedure reports ☐ Emergency Department record ☐ Laboratory reports (including drug screens)	☐ Radiology or x-ray reports ☐ Interdisciplinary records (progress notes) ☐ Medication Lists and Documentation ☐ Nursing notes ☐ Physician orders ☐ Other _____
Sensitive Information	I understand that the information in my records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.	
Right to Revoke	I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing via mailing or faxing to one of the locations listed above. I understand that revocation will not apply to information that has already been released based on this authorization.	
Expiration	Unless otherwise revoked, this authorization will expire on the following date or when the following event or condition occurs: _____ If I do not specify an expiration date, event, or condition, this authorization will expire in 60 days.	
Redisclosure	I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.	
Other Rights	I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. Research participation requires a separate authorization by the patient. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions about disclosure of my health information, I can contact the Health Information Management (HIM) Department by calling the number listed above.	

Print Name: _____ Date: _____ Time: _____

Signature of Patient or Legal Representative *: _____

If Signed by Legal Representative, relationship to patient _____

Legal representative must provide a copy of guardianship, Executor of Estate, or Power of Attorney (POA) documents

Office Use Only: Received by: _____ Medical Record number: _____ Date Received: _____

Copy to individual