

AUTHORIZATION FOR PATIENT RECORDS

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

<input type="checkbox"/>	Disclosed TO:	<input type="checkbox"/>	Obtained FROM:	OhioHealth Endocrinology Physicians 295 Glessner Avenue Mansfield, Ohio 44903 Telephone: (419) 522-2734 Fax: (419) 522-2240
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<input type="checkbox"/>	Disclosed TO:	<input type="checkbox"/>	Obtained FROM:	Name/Organization: _____ Address: _____ City/State/Zip Code: _____ Telephone: _____ Fax: _____
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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 Endocrinology - Glessner. 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 Endocrinology - Glessner 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 Endocrinology - Glessner, 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 testing 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:

- | | | | |
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| <input type="checkbox"/> Lab reports | <input type="checkbox"/> EKGs | <input type="checkbox"/> Consultations | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> PFTs | <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Emergency Room Reports |
| <input type="checkbox"/> X-ray reports and films | <input type="checkbox"/> Procedures | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> History/Physical Exams |
| <input type="checkbox"/> Cardiac Catheterizations | <input type="checkbox"/> 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: (_____) _____