Family Health Care, LLC
72 N Plaza Blvd
Chillicothe, OH 45601
740-851-4400
740-851-4403

AUTHORIZATION TO RELEASE OF INFORMATION

1. PATIENT INFORMATION | **MRN (OFFICE USE ONLY):**

Last Name	First	Middle	Maiden
Address	City	State	Zip
DOB	SSN (LAST 4 DIGITS)	Preferred Phone	☐ LEAVE MESSAGE (CHECK TO LEAVE MESSAGE)

2. REASON FOR REQUEST

☐ CONTINUITY OF CARE - MEDICAL TREATMENT ☐ INSURANCE ☐ LEGAL REASONS ☐ DISABILITY
☐ RESEARCH ☐ ADOPTION ☐ EMPLOYMENT RELATED
☐ Other (Describe)

3. DATES OF SERVICE TO BE RELEASED:

DATE/YEAR OF SERVICE(S): FROM TO *or **ALL DATES OF RECORD***

4. RECORDS TO BE RELEASED (CHECK ALL THAT APPLY):

☐ AFTER VISIT SUMMARY ☐ OPERATIVE REPORT(S) **PLEASE SPECIFY:**
☐ DISCHARGE SUMMARY ☐ EMERGENCY DEPT. REPORT(S) ☐ RESULTS:
☐ HISTORY AND PHYSICAL ☐ PATHOLOGY ☐ OTHER:
☐ CONSULTS ☐ COMPLETE RECORD ☐ PHYSICIAN OFFICE NOTES:

5. DELIVERY METHOD:

☐ US MAIL ☐ PICK-UP ☐ CD
☐ EMAIL ☐ MYCHART ☐ CIOX E-PORTAL
(Limited per file size)
Email Address

The CD/email you have requested is encrypted. If you agree to have the encryption removed by OhioHealth, please initial below. By removing the encryption, your personal health information will no longer be secured.
INITIALS:

6. RELEASE TO:

NAME OF PERSON/ORGANIZATION/CLINIC: **Family Health Care LLC 72 N PLAZA BLVD. CHILLICOTHE, OHIO 45601 FAX: 740-851-4403**

7. PROHIBITION ON REDISCLOSURE:

I understand this information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR part 2) may prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal law.

8. FEES: Per Ohio Revised Codes and HIPAA, there may be a charge for copying medical records

9. AUTHORIZATION AND EXPIRATION:

+ I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the privacy regulations.
+ OhioHealth will not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign the authorization when the prohibition on condition of authorizations applies.
+ I understand by signing this authorization it gives the researcher(s) the permission to use or disclose my personal health information for such research.
+ I understand that my records/protected health information cannot be released unless I sign this form.
+ **I understand that this authorization may include information concerning testing, diagnosis, or treatment of HIV (Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome), PSYCHIATRIC and/or DRUG/ALCOHOL TREATMENT and/or ASSAULT RECORDS that may be in my medical record.**
+ As described in the Notice of Privacy Practices of FAMILY HEALTH CARE, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by FAMILY HEALTH CARE in reliance on this authorization, by sending a written revocation to the entity's Health Information Management Medical Records Department. If this authorization has not been revoked, it will expire on the date or event stated below. If no date is specified below, the authorization will remain in effect for a maximum of one year.

Expiration Date or Event:

X Signature of Patient _____
Date_____
Signature of Individual Authorized by Patient _____
Date_____
Relationship to Patient_____