MORROW COUNTY HOSPITAL
HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO RELEASE/OBTAIN INFORMATION
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Patient Sticker

1. PATIENT INFORMATION

AUTHORIZATION TO RELEASE INFORMATION			**MRN**
LAST NAME	FIRST	MIDDLE	MAIDEN
ADDRESS	CITY	STATE	ZIP
DOB	SOC. SEC.	WORK PHONE	HOME PHONE

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

- ☐ CONTINUITY OF CARE / MEDICAL TREATMENT (Minimum Document Set section below)
- ☐ DISABILITY (Minimum Document Set section below)
- ☐ CONTINUITY OF CARE (Minimum Document Set section below)
- ☐ CHANGING DOCTOR / MOVING FROM AREA (Minimum Document Set section below)
- ☐ PUBLIC DISCLOSURE OF PROTECTED HEALTH INFORMATION (IF yes – SKIP TO SECTION 6)
- ☐ OTHER (Specify) _____
- ☐ EMPLOYMENT RELATED
- ☐ INSURANCE
- ☐ LEGAL REASONS

3. RELEASING RECORDS

INFORMATION TO BE DISCLOSED FROM: (check as many as applicable)

- ☐ MORROW COUNTY HOSPITAL
- ☐ Other _____

4. RECORDS/DOCUMENTES (TYPE)

SPECIFY TYPE OF RECORD REQUESTED: **DATE OF SERVICE(S):**

- ☐ INPATIENT _____
- ☐ OUTPATIENT CARE CLINICS _____
- ☐ EMERGENCY ROOM _____
- ☐ OUTPATIENT _____
- ☐ OTHER _____
- ☐ DATE/SERVICES TO BE EXCLUDED FROM RELEASE (i.e. ***HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC, OR DRUG/ALCOHOL TREATMENT AND/OR ASSAULT RECORDS that may be in your medical record.***

Please specify : _____

Content to be Released – For the record(s) selected above, specify content in area below, as either, Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all of the documents listed above.

☐ **COMPLETE RECORD**

MINIMUM DOCUMENT SET (check one or more of the documents, or all)

- ☐ FACESHEET
- ☐ DISCHARGE SUMMARY
- ☐ HISTORY AND PHYSICAL
- ☐ CONSULTS
- ☐ OPERATIVE REPORTS
- ☐ EMERGENCY DEPT REPORTS
- ☐ PATHOLOGY
- ☐ TEST RESULTS (lab, radiology, EKGs, EEGs, Echo. Etc.)
- ☐ OTHER _____
- ☐ ALL OF THE ABOVE

ADDITIONAL DOCUMENT SET (comprised of Minimum Document Set, plus each of the following selected):

- ☐ PHYSICIAN ORDERS
- ☐ PROGRESS NOTES
- ☐ NURSING NOTES
- ☐ GRAPHICS
- ☐ PHYSICIAL THERAPY/SOCIAL SERVICE NOTES
- ☐ NUTRITION SERVICES NOTES
- ☐ CONSENTS
- ☐ MEDICATION LISTS
- ☐ ANESTHESIA RECORDS/OTHER SURGERY DOCUMENTS
- ☐ OTHER/MISC _____

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5. RECEIVING RECORDS

INFORMATION TO BE DISCLOSED TO (Person/Agency/Organization)		ATTN:	
ADDRESS	CITY	STATE	ZIP
PHONE#			
☐ Review Only (DATE AND TIME) _____	☐ FAX TO:	FAX#	

6. MEDIA PUBLIC DISCLOSURE

For Marketing and Communications Use only.

I AUTHORIZE THE PUBLIC DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS DESCRIBED BELOW:

☐ Name and age ☐ City of residence ☐ Hospital admission, discharge or treated/released status

☐ Brief extent of injuries or illness ☐ Diagnosis, treatment, prognosis ☐ Photographs, videotape or audiotape

☐ Other (describe) _____

FOR THE PURPOSE OF: ☐ Hospital produced publications/promotions/advertising ☐ Hospital events/presentations/projects

☐ Hospital web-site ☐ Educational purpose/professional conferences ☐ All news media

☐ Other use (describe) _____

7. AUTHORIZATION

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 federal privacy regulations.
- I understand that treatment or payment of my claim will not be impacted by not signing this form. Research related treatment is strictly voluntary.
- I understand that my records/protected health information cannot be released unless I sign this form.
- As described in the notice practices of Morrow County Hospital I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken Morrow County Hospital in reliance on this authorization, by sending a written revocation to: Morrow County Hospital's Health Information Management Department, 651 West Marion Road, Mount Gilead, Ohio 43338.

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 that may be in my medical record.

8. EXPIRATION

This authorization for release of protected health information for the date of service indicated is effective until _____ or maximum of one year from the date signed below.

I hereby authorize Morrow County Hospital to disclose to the party (parties) names in this document, information from my medical record for the reasons and time specified.

X Signature of Patient _____ Date _____ Time _____

Signature of Individual Authorized by Patient _____ Date _____ Time _____

Relationship to Patient _____ Witness: _____

9. REDISCLOSURE

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) prohibit you from making any further disclosure of this information except with the 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.

10. FEES

According to Ohio Revised Codes there is a per page fee for records. The fee will be dependent upon the number of copies requested and other reasons as specified in ORC 3701.741 at codes.gov/ORC

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