AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

Name:____ Phone#:_______________________________

Address:______________________________________ Date of Birth:___________________________

____

RELEASE INFORMATION FROM:

Healthcare Provider:______________________________

____

Address:______________________________________

____

Phone:_______________________________________

Fax:____

RELEASE INFORMATION TO:

Ohio Hills Health Services

101 East Main St

Barnesville, Ohio 43713

Phone: 740-239-6447

Fax: 740-425-4202

Purpose of disclosure: ____

Date of Service (FROM): _______________________________(TO)____________________________

___Office Visit	___History and Physical	___PT/OT Reports
___ ER Reports	___Cardiac Reports	___ Homecare Reports
___ Discharge Summary	___ Lab Reports	___ Radiation/Oncology Report
___ Operative Reports	___ Radiology Reports	___ Mammogram Report
___Colonoscopy/Sigmoidoscopy		___Pap testing report
Other____________________________		

I, the undersigned authorize____ to release health information as indicated/described above. I understand and acknowledge that the requested health information regarding physical and mental illness, HIV tests results or diagnosis, treatment for AIDS/AIDS related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. Release of Psychotherapy Notes require a separate authorization.

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, and eligibility for benefits will not be based on whether I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

Signature of patient/legal representative: ____

Printed Name____

Relationship, if not patient____

Date: ____

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record*

revised 1/2020